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Citation: Peter, Sarah (2017) Child psychotherapy with children who are medicated for ADHD : discourse, power and interdisciplinary practice. [Thesis] (Unpublished)

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**Child psychotherapy with children who are
medicated for ADHD:
Discourse, power and interdisciplinary practice**

**Portfolio Doctorate
DPsychotherapy
Birkbeck College, University of London**

The work presented in this thesis is all my own:

Sarah Peter, September 2016

Word count: 36,753

Abstract

This study empirically investigated the under-explored practice of combining psychoanalytic psychotherapy with medication in the treatment of children diagnosed with ADHD. Semi-structured interviews were conducted with six child psychotherapists who had provided psychoanalytic treatment to children medicated for ADHD. The data were analysed thematically and discursively, paying attention to the social and performative functions of language in interaction. The interview material was characterised by double messages of explicit support for and implicit resistance to the practice of combining medication and psychotherapy, thus suggesting that the metaphorical 'marriage' of psychoanalytic and psychiatric practice was only superficially well-functioning. This was expressed through three interpretative repertoires – **A marriage of convenience**, **Separate lives**, and **For the sake of the children** – which were employed by participants to negotiate differential power relations and attributions of blame in the field of ADHD. The study found:

1. An unacknowledged paradigm clash between psychoanalytic and medical models of ADHD
2. A dissonance between a proclaimed complementarity between psychoanalytic and psychopharmacological interventions, and an absence of mutually enriching collaboration in practice
3. Psychotherapists appear to be ambivalent and only superficially accepting of and compliant with the medical model of ADHD

These findings add to the existing literature by highlighting the challenges of a multi-perspective approach in this contested area. Suggestions are made for practical action aiming to foster open interdisciplinary exchange and debate, and broader public and professional dialogues about ADHD.

Acknowledgements

I would like to thank the child psychotherapists who generously and enthusiastically offered their time to join me in this investigation.

I am also indebted my teachers and colleagues on the child psychotherapy training. In particular to Julia Mikardo and Bobbie Cooper, who not only took seriously and supported my research endeavours, but also helped me carve out the time and space to pursue them. And to Eva Crasnow, for proving that it is possible to finish one of these, and convincing me that I could do it too.

My sincere thanks also go to my two supervisors, Viviane Green, for guiding me with patience and wisdom, and Bruna Seu, for helping me make new discoveries with humour and kindness.

Finally, thank you to my parents, Beverly and Leonard, my husband, Steve, and my little boy, Elijah. Without your support, I would have abandoned this project long ago.

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Chapter One: Introduction

I mean it's something I struggle with because there's a bit of me that doesn't quite believe in it at all. You know, that, that thinks that when we talk about a, a deficit of attention, it often seems that it's the parental deficit of attention to the child rather than the child having any sort of deficit. Um, having said that, I've seen people improve substantially on medication which would sort of counteract that view that it's, you know, that it's not really a proper thing but I, I don't know. I'm sort of quite doubtful about it. Um, and I, I don't know enough to know how, you know, whether scans show up something different in the brains of children with it or anything of that sort. It feels to me quite a loose diagnosis. And certainly something that I've been aware of over sort of years is the, is the Connors questionnaire¹. You know, which people are given to see, you know, to sort of help people, to help the professional decide whether the child has ADHD. And, and some of the questions on it I think are ridiculous. I mean, they may have changed it but it used to be you know, one of the questions was, you know, 'Does your child resist sitting down and doing homework?' And I used to think show me one that doesn't! You know, sort of, that it's, it often seems to me that the whole thing is about an adult or adults finding the child's behaviour intolerable and wanting to sort of dampen down what they find intolerable. Rather than it necessarily being something that sort of bothers the child massively. But I have seen, you know, children who are very, very hyper, very unable to settle, very unable to sort of concentrate, who have been helped by the medication. So, you know, I'm sort of, I don't have a sort of clear, clear idea in my head about it really.

Deborah's rapidly oscillating account captures the elusiveness that was a significant feature of my experience of investigating the subject of conducting child psychotherapy with children who are medicated for attention deficit hyperactivity disorder (ADHD). Her narrative exemplifies the intriguing mixture of vociferousness and hesitancy that characterised my conversations with child psychotherapists, and encapsulates the dilemmatic and contradictory features of their accounts of their work in this complex, contentious field. In this introduction I begin by giving a brief overview of the context for this study, the methods chosen to investigate this area, and the findings that emerged. This is followed by an outline of the remaining chapters in this thesis.

Study overview

Research and intervention into children diagnosed with ADHD take place in a fiercely contested field in which consensus regarding definition, prevalence and treatment is yet to be reached. At the same time, in recent years diagnosis and prescription of

¹ A rating scale filled in by parents and teachers that can be used as part of the assessment of a child for ADHD.

medication for this psychiatric diagnostic category has steeply increased (Timimi and Leo, 2009). Recommended treatment is medication and behavioural intervention (National Institute for Health and Care Excellence (NICE), 2008), although as yet neither treatment has been shown to improve both core symptoms and long-term functioning (Chronic et al, 2006; Verkuil et al, 2015). Although psychoanalytic treatments are rarely recommended or sought for ADHD, child psychotherapists in the UK working with children with complex needs often treat children diagnosed with and medicated for ADHD (McLoughlin, 2009). As such, combined psychoanalytic and psycho-pharmaceutical interventions are becoming increasingly common. Alongside this, psychoanalytic clinicians and researchers active in the field of ADHD emphasise the importance of interdisciplinary dialogue, arguing that psychoanalytic treatments can be enriched by better understanding of biological determinants, and vice versa (Leuzinger-Bohleber et al, 2010). These authors also highlight the need for more empirical research into psychoanalytic interventions into ADHD. While some studies suggesting efficacy of psychoanalytic treatment exist (Fonagy and Target, 1994; Leuzinger-Bohleber and Fischmann, 2010; Leuzinger-Bohleber et al, 2011) there has been no empirical investigation of the combination of medication and psychoanalytic psychotherapy for ADHD. This research was designed to address this gap in the literature.

The data for this study were gathered by conducting semi-structured interviews with six psychoanalytic child psychotherapists. Detailed reflections on the research process also formed part of the data set. The initial analysis was thematic; however this analytic tool proved insufficient in interrogating the dissonances and contradictions found within the interview material. Two separate strands of discourse analysis were applied therefore to further interrogate the interview data. Taking a Discursive Psychology approach, detailed attention was paid to the rhetorical, stylistic and descriptive features of my conversations with participants. This led to the identification of constellations of linguistic, descriptive, stylistic or grammatical features, termed 'interpretative repertoires' (Wetherell and Potter, 1992, p.89), which are employed by speakers to construct particular versions of themselves, others, actions and events in talk. Participants' ways of talking were characterised by a double message, in which they conveyed both explicit support for and implicit resistance to the use of medication alongside psychotherapy. An explicit message of belief in the usefulness of combining the two treatment approaches was undermined by descriptions of clinical experiences,

and by implicitly or indirectly critical communications about the use of medication alongside psychotherapy. This account of the metaphorical 'marriage' between medication and psychotherapy as only superficially well-functioning was expressed through three interpretative repertoires. **A marriage of convenience** entails ambivalent acceptance of and superficial compliance with the view of psychoanalytic and drug treatments as compatible and mutually beneficial. **Separate lives** entails the adoption of an agnostic or indirectly critical position regarding the use of medication. **For the sake of the children** encompasses the conflicting ways in which both medication and psychotherapy are constructed as potentially beneficial to children. Foucauldian Discourse Analysis was then applied to examine the broader cultural and historical discourses that inform the use of these interpretative repertoires. It is argued that the double messages found in participants' accounts of their work in this field emanate from child psychotherapists' enactment in a site of uneven power relations. The ambivalent, compliant, avoidant or contradictory positions adopted by participants when talking about the research subject were understood in the context of medico-neurological² hegemony, the marginalised status of child psychotherapists and the negotiation of polarising attributions of blame in the field of ADHD.

This research produced three central findings regarding child psychotherapy with children medicated for ADHD:

1. An unacknowledged paradigm clash between psychoanalytic and medical models of ADHD
2. A dissonance between a proclaimed complementarity between psychoanalytic and psychopharmacological interventions, and an absence of mutually enriching collaboration in practice
3. Psychotherapists appear to be ambivalent and only superficially accepting of and compliant with the medical model of ADHD

² Throughout this thesis, the terms 'medical' and 'medico-neurological' are used interchangeably to denote an approach which treats ADHD as the result of largely inborn neuro-chemical processes in the brain, effective treatable with medication. This is discussed in greater detail in the review of the literature in Chapter Two (p.14). It is important to note that I have chosen this term to refer to a specific type of psychiatric approach to ADHD, therefore avoiding making the reductive assumption that all psychiatric practice is informed mainly by a biomedical model. When referring to psychiatric research and practice driven principally by a biomedical perspective, I use Nikolas Rose's (2007) term 'biological psychiatry' (see p.85).

These findings add to the literature by identifying obstacles to productive interdisciplinary exchange regarding ADHD. In the light of these findings, the thesis concludes with a discussion of practical action that could be taken to mitigate the normalising effects of powerful discourse and to facilitate open, authentic and creative cross-disciplinary dialogue in the sphere of ADHD.

Outline of thesis

Following this introduction, this thesis is divided into five further chapters:

Chapter Two: Literature review

This chapter begins with a summary of the main theoretical perspectives on the development and treatment of ADHD. The current state of the evidence for each of these perspectives is also reviewed. Particular attention is given to psychopharmacological and psychoanalytic approaches to ADHD, as well as to the limited literature on the combination of both. This is followed by a discussion of the rationale for the current study and the development of the central research question, which became: *How do child psychotherapists talk about their experiences of treating children who are medicated for ADHD, and what are the actions or functions achieved by these ways of talking?*

Chapter Three: Methodology

This chapter outlines the epistemological and ontological positions that informed this study. It describes how the research process induced a shift from attempting to understand the true nature of child psychotherapists' experiences, to exploring and interpreting how these experiences are 'talked into being' (Willig, 2001, p.103). After detailing the research methods employed to investigate this subject, the six central themes produced by the initial thematic analysis are discussed. These are:

1. ***Acceptance/approval*** of the use of medication alongside psychotherapy
2. ***Ambivalence/uncertainty*** regarding the use of medication alongside psychotherapy
3. ***Inequality*** within the field of ADHD
4. ***Meaningful communications*** presented by ADHD symptoms
5. ***An alternative position*** taken up by child psychotherapists to the prevailing medical model of ADHD.

6. **Communication breakdown** in conversations about the combining ADHD and medication

Chapter Four: Data Analysis I

This chapter presents in detail the discursive analysis that was applied to elicit a deeper understanding of the variations and contradictions identified in the initial thematic analysis. Using a Discursive Psychology approach (Willig, 2001), three interpretative repertoires employed by participants are elucidated. These are:

A marriage of convenience: In this repertoire successful collaboration between psychoanalytic and psychopharmacological treatment approaches is characterised as desirable but unobtainable, or valuable for its legitimating function. Participants repudiate potential accusations of being automatically opposed to medication and position themselves as ambivalently accepting of or superficially compliant with the use of medication alongside psychotherapy.

Separate lives: In this repertoire participants avoid directly challenging the use of medication and disavow the ability to provide reliable views on the use or impact. Participants disclaim potential attributions of being unthinkingly dismissive of the medical treatment, and position themselves as agnostic about or indirectly critical of the use of medication alongside psychotherapy.

For the sake of the children: This repertoire encapsulates conflicting treatment paradigms. Medication is presented as a desperate measure to help families in crisis, while psychotherapy is presented as resisting the treatment of distressed or distressing behaviour as meaningless symptoms to be eradicated with medication. Participants position themselves as limited in their capacity to resist the use of medication, despite their construction of psychotherapy as an effective alternative treatment.

Chapter Five: Data Analysis II

This chapter draws on Foucauldian Discourse Analysis (Willig, 2001) to investigate the broader cultural and historical discourses that inform the interpretative repertoires identified in the previous chapter. The ambivalent acceptance and superficial compliance which characterises **A marriage of convenience** is understood as functioning to preserve the legitimacy and compatibility of child psychotherapy with

dominant paradigms of treating and knowing about ADHD. The agnosticism towards and implicit criticism of the practice of medicating children elucidated in **Separate lives** is viewed as working to sidestep confrontation with a more powerful partner and to avoid identification with a reductive discourse of parent-blame. In **For the sake of the children**, the construction of medication as a desperate yet necessary measure, alongside the construction of ADHD as distress that can be understood and transformed in the therapeutic process, are interpreted ways of negotiating polarising attributions of individual versus parental responsibility for emotional distress.

Chapter Six: Findings and conclusions

The chapter discusses the three key findings that emerged from this study and their implications for the quest for a multi-perspective approach to ADHD. Suggestions are made for action to facilitate greater interdisciplinary collaboration in practice. The thesis concludes with reflections on the research process and recommendations for future research.

Chapter Two: Literature Review

This chapter summarises the main theoretical perspectives on the development and treatment of ADHD, as well as the current state of the evidence for each of these perspectives. Particular attention is paid to psychopharmacological and psychoanalytic approaches to ADHD, as well as to the limited literature on the combination of both. The chapter ends with a discussion of the rationale for the current study.

Attention-deficit/hyperactivity disorder (ADHD)

ADHD is the most common psychiatric diagnosis given in childhood (Gunter, 2014). The term ADHD originates in the American *Diagnostic and Statistical Manual of Mental Disorders*. According to the current, fifth version of this manual (DSM-5™) ADHD can be diagnosed when questionnaires and interviews with child and parent, as well as direct observations of the child, are interpreted as demonstrating that at least six symptoms of inattention and/or hyperactivity-impulsivity, inconsistent with the child's developmental level, have been present for a minimum of six months, in two or more settings, e.g. at home and at school (American Psychiatric Association (APA), 2013). Symptoms must be thought to be negatively impacting on the child's functioning or development, and in younger children they are required to have been present before the age of seven. The official diagnostic manual employed in Britain, the 10th revision of International Statistical Classification of Diseases and Related Health Problems (ICD-10), does not use the term ADHD, but instead refers to hyperkinetic disorder (HKD). HKD is diagnosed according to narrower and more stringent criteria than the American version. To qualify for a diagnosis of HKD children should exhibit signs of *both* hyperactivity/impulsivity and inattention, rather than one or the other (WHO, 1992). This manual also cautions against the diagnosis of ADHD in preschool children unless extreme levels of hyperactivity appear to be present. Although these differences are reflected in the greater willingness of American psychiatrists to diagnose and medicate for ADHD (Hart and Benassaya, 2009), the term ADHD is widely used in Britain (Timimi, 2002) and European and North American prevalence figures for this diagnosis are now comparable (Salomonsson, 2011).

The debate surrounding the provenance of the group of behavioural symptoms required for an ADHD diagnosis is vast and furious. So too are the ongoing discussions

and disputes about how and whether to intervene with children deemed to meet these diagnostic criteria. In recent years diagnosis and prescription of medication for ADHD have steeply increased (Timimi and Leo, 2009). ADHD is thought to affect approximately 2.2% of males and 0.7% of females worldwide (Erskine et al, 2013). In the UK it is estimated that around 3 to 9% of school-aged children qualify for a diagnosis of moderate ADHD, with 1 to 2% meeting the criteria for severe ADHD associated with serious impairment³ (NICE, 2008). However, reports from epidemiological studies vary greatly worldwide, ranging from 0.5% to 26% of school-aged children (Timimi and Leo, 2009). Explanations for variations in global prevalence and treatment rates include over- and under- diagnosis in certain populations, the subjectivity and cultural biases of the interview and observation-based diagnostic framework, differences between the ICD and DSM criteria, the influence of the financial interests of the pharmaceutical industry, and the lack of high quality experimental data on drug treatments (Verkuijl et al, 2015). These factors, in addition to the fact that as yet no single causative factor in the development of ADHD has been identified (Salomonsson, 2011), fuel the considerable debate about the nature and management of symptoms of ADHD.

Medico-neurological model

I use the term 'medico-neurological' here to refer to the account of ADHD as the result of largely inborn neurochemical processes in the brain, effectively treatable with (usually) stimulant medication. Mainstream child psychiatry, academic psychology and ADHD self-help groups emphasise the biological and cognitive origins of ADHD (Barkley, 1998; Bilbow, 2004; Taylor and Timimi, 2004). Accordingly, the account of ADHD as discrete medical disorder linked to neurological deficits (Barkley et al, 2002) is widespread in academic, clinical and popular literature on the subject (Rafalovich, 2001a). In this model, genetically-determined abnormalities in certain brain regions or in nerve cell receptor sites are proposed as the primary cause of ADHD symptoms (Cantwell, 1996; Barkley, 1997; Kutcher et al, 2004). Since ADHD is explained as 'a

³ ADHD is also sometimes referred to as attention deficit disorder (ADD). ADD is a sub-type of the disorder found in the American classification system, which allows for less severe sub-types of diagnoses for children displaying either predominantly inattentive or predominantly hyperactive-impulsive type behaviours. In the UK children meeting the criteria of ADD would usually be diagnosed with 'moderate' ADHD. HKD does not allow for sub-types of ADHD, so is roughly equivalent to the ADHD combined-type diagnosis found in the DSM-5. Children meeting all the criteria for HKD would be likely to receive a diagnosis of 'severe ADHD'.

developmental failure in the brain circuitry that underlies inhibition and self control' (Barkley, 1998, p.67), adverse environmental factors such as relationship difficulties are understood as consequences rather than causes of ADHD symptoms. Associations between diagnosis of ADHD and decreased brain volume (Krain and Castellanos, 2006) and between ADHD and genes linked to dopaminergic and serotonergic pathways (Verkuijl et al, 2015) are held to corroborate this perspective. Twin studies, in which identical twins show higher concordance in ADHD symptoms than fraternal twins, are cited as evidencing the strong heritability of ADHD, which is thought to suggest genetic causes (Faraone et al, 2005). Links between adverse experiences and ADHD symptoms are explained with a 'predisposition-stress' model, which holds that genetic potentialities are triggered by environmental factors (Joseph, 2009, p.59). The efficacy of stimulant medication in reducing hyperactive, inattentive and impulsive behaviour is also cited by some as proof of the neurological roots of ADHD, since it is thought to act on defective neurotransmitters (Miller and Leger, 2003).

Although less visible in the public sphere, academic, cultural and clinical critiques of the medico-neurological model of ADHD abound. The lack of objective test for ADHD, the failure to locate a specific gene causing the cluster of symptoms (Furman, 2009; Timimi, 2011) and the non-specific action of stimulant medication (Gunter, 2014) are cited as undermining claims that ADHD can be considered a mono-causal 'disease'. The assumptions of twin adoption research on ADHD have been criticised for failing to adequately acknowledge or control for the impact of environmental factors (Joseph 2011)⁴. Some argue that financial and status interests drive collusion between prominent psychiatric researchers and the pharmaceutical industry, so that research methodologies and funding are prejudiced in favour of studies confirming the hypothesis that stimulant medication is necessary and effective (Furman, 2009; Timimi 2011). Critics of the medico-neurological model state that the presumption of a biological aetiology leads to a reductive but pervasive neurobiological account that strips ADHD symptoms of their meaning (Jones, 2002), blames children while exonerating parents (Breggin and Breggin, 1994), risks retraumatising children by failing to recognize deficits in their caregiving environment (Erdman, 1998) and blinds

⁴ It has been argued that findings from contemporary twin research show that identical twins tend to experience higher environmental concordance than fraternal twins, therefore undermining the claim that the higher concordance of ADHD symptoms in identical twins is conclusive evidence of a genetic cause (Joseph, 2011).

clinicians and parents to alternative explanations for disruptive behaviour (Johnston et al, 1998; Overmeyer et al, 1999). The dominance of the medico-neurological approach has been attributed to the increasing centrality of short-term treatment models in child mental health provision, necessitating a focus on symptom-relief via drug therapy and cognitive or behavioural treatments over longer-term treatments aiming to understand the complexities of context, emotional distress and family dynamics (Jones, 2002).

Psychosocial models

Psychosocial models of ADHD encompass psychological, social and cultural and psychoanalytic approaches, which emphasise the role of intrapsychic, contextual and family dynamics. Psychosocial approaches usually stress the heterogeneity of potential causes for symptoms of ADHD, critiquing its status as a discrete illness or disorder and cautioning that it therefore may be over-diagnosed or invalid as a diagnosis (Jones, 2002; Bailly, 2005). Following a brief overview of other psychosocial explanations for ADHD, this review focuses on psychodynamic and psychoanalytic theories.

Family dynamics/parenting styles

Links between the caregiving environment and the development of ADHD are suggested by research showing correlations between levels of maternal sensitivity, attachment patterns and children's externalizing behaviour (Bradley and Corwyn, 2008; Fearon and Belsky, 2011). Less effective parenting practices have also been shown to contribute to the severity of children's disruptive behaviour (McLaughlin and Harrison, 2006). Child temperament has been identified as an important variable in the development of ADHD. Mismatches between parental and child personalities or the combination of difficult infant temperament and suboptimal parenting environment are thought to pose the greatest risk for the development of ADHD symptoms (Lehmkuhl, 2010).

Environmental and social factors

Environmental predictors of ADHD are thought to include high levels of television watching before age three (Christakis et al, 2004), hearing impairments (Bennett et al, 2001), artificial colourings in diet (Puri, 2009) and early psychosocial adversity (Hjern et al, 2004; Thapar et al, 2013). ADHD diagnoses are also made more frequently in

populations at socioeconomic disadvantage, such as financial or housing difficulty or families with younger or single parents (Russell et al, 2015).

The impact of culture

The impact of societal developments and practices in Western culture, such as the fast pace of digital and media culture (Gunter, 2014), the demands of post-industrial educational practices requiring children to sit still and concentrate for prolonged periods (Kriegman, 1999) and the increasingly fragmented domestic arrangements and complexities of globalization (Timimi and Maitra, 2009), have all been hypothesized as producing behaviours associated with ADHD or as necessitating the cultural construct named ADHD.

The biopsychosocial perspective

ADHD viewed as multifactorial in genesis is an important strand in the psychosocial perspective. In this view genetic, environmental and cultural factors are all thought to contribute to the development of ADHD (Diller 1998; Taylor and Timimi, 2004; Verkuil et al, 2015). Proponents of this theoretical perspective urge caution in diagnosing and treating ADHD, due to the complexity of the factors causing, maintaining and exacerbating this presentation. Pozzi-Monzo (2012) cites Michael Rutter's warning against inappropriate interpretations of the term 'genetic' to mean fixed and deterministic rather than probabilistic and contingent on environmental interaction. The biopsychosocial perspective can be weighted more or less towards biological or psychosocial features. For example Leuzinger-Bohleber et al (2010) cite leading German ADHD researchers Lehmkuhl and Dopfner as understanding genetic disposition to neurochemical dysfunction as producing disturbances in self-regulatory capacities. These are thought to cause ADHD symptoms, which in turn impact the quality of the child's relationships and educational attainment, leading to secondary emotional and interpersonal difficulties. In contrast Leuzinger-Bohleber et al themselves highlight the importance of pathological early caregiver interactions in arresting both neurobiological and psychic development, producing the neurochemical differences and behavioural symptoms associated with ADHD. These authors argue therefore that 'societal and cultural factors should thus be taken as seriously as findings from modern neurobiology and brain research' (2010, p.145).

Psychoanalytic and psychodynamic models

In this section I review approaches to ADHD based on psychoanalytic principles⁵. Psychodynamic and psychoanalytic approaches conceptualise ADHD symptoms as the manifestation of psychic deficits or conflicts with multiple possible origins (Lehmkuhl, 2010; Gunter, 2014). In this sense they tend to be critical of the status of ADHD as a single, explanatory diagnostic category, which does not interrogate the meaning of behaviour (Jones, 2002). The centrality of the nuances of individual endowment and personal experience to the psychoanalytic understanding of ADHD is reflected by the inclusion of detailed case histories in both the theoretical and the empirical literature on this subject⁶.

Psychoanalytic and psychodynamic perspectives on ADHD can be divided into those drawing on ego-psychology theories and those drawing on object-relations theories (Conway, 2012). Although situated in distinct theoretical schools, both these approaches give prominence to the impact of early relationships in the development of ADHD. Ego-psychology theories, more prevalent in the United States, emphasise deficits in the ego functions of synthesising, analysing and integrating experiences and interpreting reality, upon which capacities for self-regulation, self-observation, self-reflection and superego development depend. These disturbances in ego integration are thought to develop in the early relational context and result in the constellation of behaviours that make up an ADHD presentation (Gilmore, 2000; Bird, 2001; Carney, 2002a; Sugarman, 2006). Object-relations theories also link ADHD to early relationship deficits (Orford, 1998; Widener, 1998). Inadequate affect sharing and affective mirroring by the primary caregiver are understood as diminishing the child's capacity to regulate painful affects (Jones, 2002; Pozzi-Monzo, 2012). Symptoms of hyperactivity, inattention and impulsivity are therefore thought to be maladaptive ways of managing intolerable emotions (Orford, 1998; Rothstein, 2002; Gensler, 2011;

⁵ A major difference between psychoanalytic and psychodynamic approaches is the higher intensity of a psychoanalytic clinical model, with greater emphasis on the dynamics of the therapist-patient relationship. However the two approaches are united by their focus on the dynamic features of psychic processes in interaction with the environment and on the role of the unconscious. For these reasons this review encompasses psychoanalytic and psychodynamic approaches to ADHD, without differentiating between them.

⁶ Leuzinger-Bohleber et al (2010, pp.21-33) present detailed case study examples of 'sub-groups' of children presenting with ADHD developed from their research. Proposed routes to ADHD in these examples include organic brain damage, early emotional neglect, trauma, cultural difference, poor environmental fit between educational setting and a highly talented child, and mourning or depression.

Conway, 2014). Salomonsson (2004; 2006; 2011) attempts to combine ego-psychological and object-relations approaches, foregrounding the influence of the child's internalization of parental objects, which are believed to affect the use of ego functions to mitigate pain and frustration through language rather than action. The absence of a robust paternal figure is also thought to be a common factor in the development of an ADHD presentation (Staufenberg, 2011; Gunter, 2014).

Drawing on the work of Wilfred Bion, Gunter (2014) proposes that ADHD develops out of deficiencies in the child's capacity to use thought to process affect, resulting in the use of impulsivity and restlessness to discharge uncomfortable feelings. Pozzi-Monzo (2012) outlines the perspective of classical psychoanalysis, which similarly treats hyperactivity as an arrest in the child's development of mental apparatus capable of replacing motor discharge to process stimuli. Again, this arrest is thought to take place in the context of a lack of adequate caregiver containment. Likewise, Leuzinger-Bohleber et al (2010, p.15) summarise the fundamental shared belief of divergent psychoanalytic schools as the view that 'stable psychic structures can only develop in adequate and empathic early object relations'. As such, attachment theory and the concepts of mentalisation or reflective functioning are also central to the psychoanalytic understanding of ADHD. Links between infant temperament, maternal sensitivity, attachment style and ADHD symptoms are held to support an understanding of ADHD as developing in the context of intergenerational attachment difficulties, via misattuned, intrusive or neglectful early caregiver interactions (Emde and Fonagy, 1997; Beebe and Lachmann, 2002). ADHD symptoms have also been viewed as the manifestation of an attachment disorder (Jones, 2002; Pozzi-Monzo, 2012). Similarly, deficiencies or delays in the development of reflective functioning in the context of difficulties in the early caregiver relationship have also been theorised as impeding self-regulatory capacities and contributing to the development of ADHD (Carney, 2002a).

Interventions and evidence

The lack of agreement about the roots of ADHD symptoms means that the appropriate treatment or support for children deemed to fit this diagnosis also remains a contentious subject, and a clear effective intervention is yet to be identified (Conway, 2012). The NICE guidelines (2008) recommend group-based parent training as the first

line treatment for school-aged children diagnosed with moderate ADHD, which can include group cognitive behavioural therapy, social skills training, and/or specific classroom interventions for the child. Drug treatment (usually psychostimulants e.g. methylphenidate, or others e.g. atomoxetine) is offered as the first line intervention for children diagnosed with severe ADHD, as well as for children with moderate impairment whose symptoms persist following behavioural intervention. However, despite NICE's recommendation that medication be given in conjunction with ongoing parent-based training, the popular view that ADHD is a mono-causal, neurological disorder easily treatable with stimulant medication is thought to have influenced users and providers of mental health services (Sugarman, 2006), and psychological or behavioural interventions have often not been sought or offered (Levin, 2002; Taylor and Timimi, 2004). Between 1995 and 2013, rates of prescriptions for medication to treat ADHD in children increased 34-fold, from 1.1 per 10,000 children in 1995 to 51.1 per 10,00 children in 2013 (Beau-Lejdstrom et al, 2016). Approximately 43% of school-age children diagnosed with ADHD are medicated for it, making psychopharmacological treatment the most commonly used intervention (Office for National Statistics, 2004). In contrast psychoanalytic and psychodynamic interventions for ADHD are considered lacking in empirical support according to the parameters of evidence-based medicine and therefore are not officially recommended by NICE. Nevertheless, child psychotherapists working with children with complex needs often treat children diagnosed with and medicated for ADHD (McLoughlin, 2009). Below the current theoretical and empirical literature on psychopharmacological, behavioural and psychoanalytic treatments for ADHD are summarised. Following this, the limited literature on the combination of psychoanalytic and drug interventions into children diagnosed with ADHD is discussed.

Psychopharmacological and behavioural interventions

Stimulant medication is thought to increase dopamine levels in the brain, leading to enhanced attention and decreased distractibility (Volkow et al, 2001). Supporters of the use of medication argue that whether ADHD is caused by genetic, social, environmental or cultural factors, or by an interaction between all of these, its symptoms carry clinical significance, particularly as predictors of poor psychosocial adjustment (Levin, 2002; Taylor and Timimi, 2004) and can be consistently improved using medication, whose side effects can be managed by adjusting dosage (Kutcher, al, 2004). The Multimodal Treatment Study of ADHD (MTA), a large American trial of

methylphenidate had significant impact on the guidance for treating ADHD, in particular on the use of medication as a first line treatment. The 14-month long study concluded that medication and combined medication and behavioural therapy are superior to behavioural therapy alone and to standard community care in improving the core ADHD symptoms of hyperactivity, inattentiveness and impulsivity (MTA Co-operative Group, 1999). However, at the study's three-year follow-up it was found that these advantages had been lost and that improvements had been maintained only in the behavioural intervention group (Jensen et al, 2007). Thus drug treatment is thought to improve ADHD symptoms in the short-term only, and to have no impact on overall functioning (Verkuijl et al, 2015). In contrast, there is little evidence for the efficacy of behavioural interventions in improving core ADHD symptoms, but they have been shown to impact management of and co-morbidities associated with ADHD, helping to improve overall functioning in social, educational and family settings (Chronic et al, 2006). Combined drug and behavioural treatments are therefore thought to be superior to single treatments in creating long-term benefits and improving areas such as social skills and parent-child relationships (Nathan, 1992; Chronic et al, 2006).

Despite the prevalence of drug treatment for ADHD, concerns have been raised about the lack of proven long-term benefits, particularly in the light of evidence that the use of stimulant medication can produce dangerous side-effects such as a potential decrease in the rate of growth, sleep disruption, vulnerability to addiction in later life and decreased neuronal plasticity (Panksepp, 1998; Jackson, 2009). Accordingly, it has been argued that the use-dependent features of brain development mean that there are less dangerous, more long-lasting ways to improve neurobiological deficits associated with ADHD, such as increasing boys' access to rough and tumble play (Panksepp, 1998). The influential MTA study has been criticised for methodological flaws, such as exposing families to pro-medication literature, lack of placebo-control or double-blinding, and the links between researchers and the pharmaceutical industry (Timimi, 2011). The validity of comparing therapeutic and pharmacological interventions has also been challenged (Jones, 2002).

Further, the non-specific action of stimulant medication in improving attention and focus in children without ADHD has led to questions about whether medication enhances performance rather than treating underlying psychopathology (Bailly, 2005; Singh, 2008). As such, some authors hold that medication is beneficial only in providing

short-term symptom relief enabling children to cope with educational demands or de-escalate relationship difficulties (Leuzinger-Bohleber et al, 2010). The absence of good enough evidence about the neurobiological origins of ADHD has also been cited in challenges to the widespread use of medication (Orford, 1998; Widener, 1998; Timimi and Leo, 2009). Critics state that the popularity and prevalence of medication for ADHD is driven not by its efficacy but by social, cultural and economic factors including stringent and contradictory expectations posed on children and families by contemporary Western society, pervasive medical discourses which privilege somatic and 'quick-fix' solutions, commercial concerns of pharmaceutical companies, supposed cost-effectiveness of drug treatments and cultural anxieties about the educational development of boys (Widener, 1998; Kriegman, 1999; Jones 2002; Timimi, 2009).

Although behavioural treatments elicit less controversy, Jones (2002) has pointed out their limitations in facilitating an understanding of hard-to-access emotions or memories, particularly for children who have had inconsistent, neglectful or traumatic early lives. Group parenting interventions have also been criticised for failing to adequately address the idiosyncrasies of the combination of the child's temperament and the parents' own temperaments and experiences (Carey, 2010).

Psychoanalytic interventions

While the number of children receiving medication for ADHD has climbed rapidly since the 1990s, the number of children receiving psychotherapy⁷ has fallen (Rafalovich, 2001a). Historically psychodynamic interventions were only offered when other treatment initiatives had been unsuccessful (Nathan, 1992). Salomonsson (2006) bemoans the failure to offer psychoanalytic treatment to children diagnosed with ADHD, stating, 'Once you see beneath their violent or scornful, indifferent or incomprehensible appearance, you notice their longing to express their inner worlds' (p.1044). Similarly, the medical and behavioural focus on symptom relief is thought to fail to pay adequate attention to the 'underlying dynamics' of the behaviour (Widener, 1998, p.269). It has also been argued that medication and short-term behavioural interventions are a false economy due to their neglect of the complexity and enduring nature of the ADHD presentation (Nathan, 1992).

⁷ In the context of this paper, the term 'psychotherapy' refers to psychoanalytic or psychodynamic psychotherapy.

Psychoanalytic treatment for ADHD therefore aims to help the child access and integrate their idiosyncratic internal states with their behaviour to help improve intrapsychic and interpersonal functioning, and eventually reduce symptoms of hyperactivity, inattentiveness and impulsivity (Orford, 1998; Conway, 2012). The use of symbols rather than action to express painful feelings is thought to be central to this endeavour (Jones, 2002). However the development of an authentic, trusting relationship with the therapist in which curiosity about thoughts and feelings can be fostered and tolerated is viewed as a necessary precursor to improvements in the capacity for symbolisation (Salomonsson, 2011; Gunter, 2014). Conway (2012) notes that regardless of theoretical orientation, all psychoanalytic treatment models emphasise the centrality of interpersonal relationships (past, present and therapeutic) to the child's capacity to make use of psychodynamic psychotherapy. The child's experience of a benign, empathic and meaningful therapeutic relationship is thought to improve self-regulatory capacities (Carney, 2002b; Jones 2002; Sugarman, 2006; Conway, 2014), either through improving his or her ability to make use of benevolent caregivers and experiences (Orford, 1998; Hopkins, 2000; Leuzinger-Bohleber et al, 2011) or through better understanding internal states through enhanced mentalisation (Nathan, 1992; Fonagy and Target, 1996; Conway et al, 2011; Staufenberg, 2011; Gunter, 2014). Made with care, transference interpretations are thought to aid this process (Conway, 2014). It has been pointed out that children with ADHD repeatedly experience negative interactions with adults that reinforce their feelings of low self-esteem, and that part of the therapist's role is to provide the child with a different experience of him or herself in the context of a relationship (Jones 2002; Conway, 2014). Therapeutic work with parents or carers is recommended alongside individual psychotherapy to facilitate understanding of the intergenerational factors impacting the child (Widener, 1998). Where necessary, intervening in the family and/or school system to alleviate anxiety is also thought to be crucial in supporting the effectiveness of individual therapy (Gensler, 2011).

A retrospective study of psychoanalytic psychotherapy with hyperactive children concluded that greater length and intensity of treatment is associated with better outcomes (Fonagy and Target, 1994). This may be due to the importance and difficulty of establishing a meaningful therapeutic alliance with children presenting with the behaviours that characterise ADHD (Jones, 2002). The preference for acting rather than thinking, impaired capacity for self-observation, levels of hyperactivity and

destructiveness, sensitivity to verbal interpretations and the possible presence of biological or cognitive deficits are all identified as potential barriers to children's capacity to make use of interpretation and tolerate the psychoanalytic frame (Orford, 1998; Gilmore, 2000; Levin, 2002; Salomonsson, 2006). Suggestions for technical modifications include greater limit setting (Gilmore, 2000), longer and more intensive treatments (Fonagy and Target, 1996), extra care about when and how interpretations, especially transference interpretations, are made (Salomonsson, 2006) and greater emphasis on process than content (Jones, 2011). Understanding ADHD as a primarily neurobiological in origin is not necessarily thought to preclude the use of psychoanalytic treatment to help patients understand and make sense of their difficulties and begin to address the resulting ego-impairment and emotional difficulties via psychoanalytic interpretation (Gilmore, 2000). Rothstein (2002, p.391) describes psychoanalysts as in a 'unique position to grasp these complex relationships' by helping the child reflect on and put into words their experience of ADHD symptoms as well as understand the unconscious fantasies and defences precipitated by them. Some also argue that the corrective emotional experience provided by psychoanalytic psychotherapy is the optimal way to address both psychic and neurobiological deficits triggered by early relational difficulties (Leuzinger-Bohleber et al, 2010).

Most of the literature on psychoanalytic interventions into ADHD comprises theoretical and case study reports. However there is a small body of research conforming to mainstream empirical criteria, by German researchers who have performed large-scale studies in this area. An assessment study into psychoanalytic early intervention with German kindergarten-aged children showed a reduction in hyperactivity (greater in girls) and aggression in treated children (Leuzinger-Bohleber et al., 2011). A randomised controlled trial of psychoanalytic psychotherapy with children aged between three and six years showed no significant impact on hyperactivity, but also demonstrated significantly decreased levels of aggression and anxiety (Leuzinger-Bohleber and Fischmann, 2010). These outcomes seem to support the claim in the theoretical literature that psychoanalytic treatment can improve emotional self-regulation.

Combined psychoanalytic and psychopharmacological interventions

Prior to this study, no empirical research into the combination of psychoanalytic psychotherapy and medication had been carried out. However, psychoanalytic

theoretical and case study literature on ADHD frequently describes treatments with children who are concurrently medicated. A proportion of this literature is critical of psychopharmacological treatment: Some authors express concerns about the widespread use of medication to address difficulties that they understand as stemming from emotional disturbance (Furman, 1996; Orford, 1998). The wish for medication itself has been understood as a psychological symptom within the family, or as a consequence of inaccurate interpretation of the term 'genetic', leading parents and carers to believe that medication is the only option (Pozzi, 2000; Pozzi-Monzo 2012). Others suggest that stimulant medication can make it more difficult to work through affect, leaving the real roots of symptoms unexplored (Widener, 1998), and stress the importance of scrutinizing the meaning of feelings of hopelessness in the treatment rather than automatically reaching for medication (Salomonsson, 2006). Wright (2006) observes that although medication for ADHD seemed to facilitate the therapeutic process in one of her adult patients, a child who she treated in both medicated and non-medicated periods displayed an increase in angry, depressive affect and a preference for action over thinking or playing whilst taking medication.

However, many authors of psychoanalytic literature on ADHD state that its complex and multi-factoral genesis of ADHD necessitates multimodal treatments which include both psychopharmacological and psychoanalytic interventions and, where needed, school and family interventions (Nathan 1992; Gensler, 2011). Furthermore, some caution against neglecting the biological aspects of ADHD, an understanding of which is thought to be important in conducting successful psychoanalytic treatment which grasps the complexities of the child's self-experience (Rothstein, 2002; Leuzinger-Bohleber et al, 2010). While drug treatments alone are not thought to be sufficient, they are considered to have potential benefits when used alongside psychotherapy. These benefits include improved psychological integration and concentration that facilitates the analytic process (Orford, 1998; Gilmore, 2000; Salomonsson, 2006; Sugarman, 2006), increased capacity for empathy and subsequent work in the transference (Carney, 2002b) and more marked representations of a helpful paternal function in the child (Gunter, 2014). Salomonsson (2011) advises that since psychotherapy does not immediately ameliorate inattention and overactivity, medication is better suited to this task. Drug treatment has been conceptualized as a 'necessary prevention measure' to help children adapt to social demands (Leuzinger-Bohleber and Fischmann, 2010, p.166) and to salvage disastrous school situations and give families thinking space

(Gilmore, 2000; Pozzi-Monzo, 2012). These emanative effects of medication are thought to facilitate psychotherapy (Whalen and Henker, 1984) by creating an atmosphere in which more complex therapeutic interventions can be take place (Nathan, 1992). Orford (1998) states that medication can provide 'a warden to control the over-active traffic of brain activity' (p.264) giving psychotherapy the opportunity to help permanently alter neural pathways via the experience of a novel relationship.

In turn, psychoanalytic treatment is viewed as capable of facilitating fruitful collaboration with other modalities, including drug treatment, for example by conducting ongoing assessment of the value and impact of medication and by attending to the emotional and relational dynamics while lie outside the reach of behavioral or medical interventions (Nathan 1992; Conway 2014). It has been suggested that medication and psychoanalytic play therapy are mutually enhancing, and that therapeutic settings are suitable arenas in which the child can process psychological reactions to taking medication (Sweeney and Tatum, 1995) or work through their understanding and experience of impairment (Nathan, 1992). Similarly, psychoanalytic techniques are viewed by some as well placed to engage with the complex symbolic meanings that taking medication may carry for a child and to deepen understanding of how stimulant medication affects feelings and behaviour (Wright, 2006). Lastly, Gilmore (2000) argues that since the positive changes effected by stimulant medication are not permanent they require stabilization, structuralisation and integration by psychoanalytic work.

The current study

In terms of interventions into ADHD, we are left with a mixed and inconclusive picture, in which a treatment model that reliably improves symptoms, quality of life and outcomes for children diagnosed with ADHD is yet to be identified. While much empirical research into the dominant medico-neurological model has been carried out, there is little evidence suggesting that psychopharmacological or combined psychopharmacological and behavioural treatments produce long-term benefits. Psychoanalytic theorists and researchers believe that psychotherapy may have the capacity to produce long-lasting effects on children's well-being, but there is a dearth of empirical literature on psychoanalytic treatments (Leuzinger-Bohleber et al, 2010; Conway, 2014).

It is only relatively recently that psychoanalytic clinicians and researchers have actively engaged with the diagnostic category of ADHD (Leuzinger-Bohleber et al, 2010). Salomonsson (2011) attributes this to the perception of ADHD as having 'a distinct and consistent neuropsychological cause' (p.87) and to psychoanalytic antipathy to using diagnostic categories based on external symptoms. However, over the last two decades, psychoanalytic interest in this field has increased. Three potential reasons for the recent surge of psychoanalytic activity in this area have been proposed (Leuzinger-Bohleber and Fischmann, 2010):

- a) The impact of findings from infant, attachment and memory research on psychoanalytic theory and technique for treating early disturbances in affect regulation, symbolisation and mentalisation
- b) Growing competition with other therapeutic interventions such as psychopharmacology and behavioural techniques
- c) The blossoming dialogue between psychoanalysis and neurobiology/brain research

In the majority of psychoanalytic accounts of ADHD, emphasis is placed on the complex interplay of biological and psychological elements (e.g. Pozzi-Monzo, 2012). Many assert that this is in line with the historical focus of psychoanalysis on the interaction between the dynamics of conscious and unconscious reactions to personal experience, and genetic or biological endowment (Gensler, 2011; Salomonsson, 2011). The links between environmental triggers and the expression of particular genes, and the role of infant temperament in determining the quality and impact of early caregiver interactions are put forward to caution against artificial or simplistic divisions between biological and psychodynamic perspectives (Carey, 2010; Leuzinger-Bohleber et al, 2010). Biological deficits are regarded as having the potential to create intrapsychic conflict and impair ego functioning, while dynamic and relational processes are thought to affect brain development (Levin, 2002; Sugarman, 2006). Support for this view is drawn from research into the neurobiology of attachment and trauma. For example, the importance of emotional exchanges between infants and their attachment figures in facilitating experience-dependent brain development (Schorre, 2001), and the capacity for trauma-induced arousal levels in the sympathetic nervous system to produce changes in the brain (Perry et al, 1995) are held to belie polarized models of ADHD and

to underscore the importance of integrating multiple perspectives and approaches in researching and treating this presentation.

My interest in the subject of conducting psychotherapy with children medicated for ADHD was triggered by my own clinical experience as a trainee child psychotherapist. Early on in my training, one of my patients received a diagnosis of ADHD soon after starting treatment with me, and began a course of stimulant medication. Although the drug treatment was introduced without consultation with me or with my supervisor, at the time I did not question or challenge this, rather considering it a taken-for-granted feature of multidisciplinary practice. It may be that my unquestioning acceptance at this time was influenced by my status as a newly-appointed, relatively inexperienced trainee. However, as reflected in the literature, the value of cross-disciplinary and multimodal treatment models is also a central feature of psychoanalytic discourse about ADHD. In the past child psychotherapists were sometimes seen as cultivating a secretive, idealised or unrealistic relationship with the child, which had to be insulated from the external world (Crockatt, 2009). However contemporary child psychotherapy practice has acknowledged the importance of finding ways to manage the dual need for dedicated focus on the child's internal world and direct contact with significant figures and institutions in their lives. Interviews for child psychotherapy training posts in CAMHS teams emphasise the clinician's location in a multidisciplinary team (MDT) and the significance of this to their practice. As such, the development of a multidisciplinary mindset and skill set was an important aspect of my training. This particular training and clinical atmosphere probably influenced my attitude towards the addition of medication into my patient's treatment, an attitude that did not question or challenge this practice, but did view it as having potential significance for the process and outcome of the child's overall treatment.

The impetus to research this area came from my apprehension of the absence of theoretical or case discussion about this type of combined treatment model, both in the clinic and at my training school. This too is reflected in the literature: Wright (2006) argues that the division between pharmacological and psychotherapeutic research and practice fuels the split between mind and body in public and professional attitudes. The recent flourishing of dialogues between psychoanalysis and neuroscience constitutes an attempt to bridge the gulf between biological and clinical research into the human mind (Music, 2009; Lehmkuhl, 2010). These approaches address emotional life at

different levels and using different tools, and integrating the two into a multi-perspective approach has been treated as both desirable and problematic (Green, 2003). Many argue that psychotherapy can work well in combination with drug treatment, yet combined psychoanalytic and psychopharmacological treatment methods have not been sufficiently integrated into psychoanalytic clinical theory (Lebovitz, 2004; Olesker, 2006; Skolnikoff, 2009), and no empirical investigations of the combination of psychotherapy and medication for ADHD have been conducted.

This study therefore aimed to address this gap in the literature. My clinical experience was a 'sensitizing concept' (Bowen, 2006, p.2), which alerted me to ask particular questions about working with my patient, such as if and how technique might vary when medication is present, and how the child might experience and understand the two aspects of their treatment. I was interested in how child psychotherapists experience psychotherapeutic work with children who are medicated for ADHD, how they understand the effect of stimulant medication on their patients, and their ideas about their patients' subjective experiences of being prescribed or taking medication. However my initial review of the literature and my experience of collecting and thematically analyzing the interview data compelled a gradual shift in focus. The participants and much of the literature adhered strongly to a message of compatibility and integration between psychoanalytic psychotherapy and medication. Yet my initial research questions were frequently rendered redundant in conversations about clinical work, in which interviewees often denied any understanding or awareness of the impact or role of medication when discussing specific cases. This raised questions about the way participants approached and presented this subject, how to understand and interpret the variability and contradictions that arose in the interviews, and how broader discourses and practices might inform child psychotherapists' ways of talking about this work. My focus therefore changed from exploring what participants did or thought about working with medicated children, onto studying the different ways in which child psychotherapists constructed themselves and their experiences when talking about this subject. The central research question became:

How do child psychotherapists talk about their experiences of treating children who are medicated for ADHD, and what are the actions or functions achieved by these ways of talking?

This question required a discursive approach. This approach eschews the quest to uncover people's 'real' attitudes, and instead attends to the social and performative aspects of language in constructing identities and objects. In the following chapter, which describes the intellectual field and methods that informed this research, I explain in detail the 'turn to language' (Willig, 2001, p.102) precipitated by this central research question, and the choice of discourse analysis as the methodological tool with which to explore it.

Chapter Three: Methodology

In this section I set out first the intellectual and theoretical foundations of my approach to this research study. I then to describe the research process, with particular attention to my own experiences of gathering, analysing and presenting the data, and the ways in which these experiences shaped and were shaped by my exploration of the research subject.

Epistemology and ontology

The question of what can be known and how this knowledge can be developed is central to the development of a coherent methodological strategy for research (Morse et al, 2002). My research question and choice of methods were moulded and refined by careful examination and clarification of my position on these issues. I initially planned to develop a theory of how child psychotherapists work with children medicated for ADHD, aiming to treat interview-generated accounts as a relatively straightforward reflection of participants' attitudes and experiences. However in the initial stages of data collection I encountered obstacles to this approach. The views and explanations I recorded in interviews with participants were variable, confusing and contradictory, and these puzzling aspects of the data necessitated a 'turn to language' (Willig, 2001, p.102). Rather than trying to understand the true nature of participants' thoughts, feelings or ideas about their work, my focus shifted to how these phenomena are constructed using language, and what effects and actions are accomplished by these particular ways of talking (Potter and Wetherell, 1987). As such the aim of this study was not to treat language as a mirror reflecting an objective reality or truth about the nature of this work. Instead I adopted a relativist ontological position, understanding language as a constructive tool creating versions of the world, which perform social actions (Potter, 1996). These versions are by their nature fluid and variable, dependent on the particular social, cultural and interactional context in which they are produced. It follows that no single version can be attributed particular validity over another. Linked to this is the social constructionist perspective informing this research, which emphasises the impossibility of producing a definitively accurate description of reality (Burr, 1995). Rather, language is used to construct different 'realities', which are always filtered through the multiple social, cultural and historical lenses of both the researcher and the researched (Denzin and Lincoln, 2005).

Researcher reflexivity

The intellectual position described above implies that my own interpretative constructions also must be treated as producing just one possible version of reality, and having their own context-specific action orientations. In conducting this research therefore, I understood myself as the author, rather than the witness or discoverer of the findings (Willig, 2001; Mills et al, 2006). Since neither the researched nor the researcher approach any field 'untouched by the world' (Charmaz, 2006, p.15), rather than striving for objectivity, the onus is on researchers to acknowledge and privilege the impact of context on the production of knowledge (Sullivan, 2002). This involves 'objectifying objectification' (Bourdieu and Wacquant, 1992, p.71), by reflecting on how the positions within the field of both the researcher and the objects of research, and their interaction, might impact the research process. Accordingly, the impact of personal and epistemological reflexivity on the study is discussed throughout this account of the research methods, as well as being embedded within the thematic analysis.

Qualitative research

Child psychotherapists' accounts of their work with children medicated for ADHD have not been explored previously in the empirical literature. As such, this was an inductive study, which used data to generate new ideas, rather than to test existing theory or hypotheses. Due to its concern with comprehending and interpreting multiple aspects of human experience (Smith, 2008) and allowing for fluidity and flexibility over the course of the research (Polit and Hungler, 1995), a qualitative research methodology was deemed a suitable approach for this exploratory study. It should be acknowledged that studies using large data sets which can be quantitatively analysed tend to be perceived as producing more objective and therefore more trustworthy results than studies using qualitative methodologies, which are generally smaller and more transparent about the subjective nature of the research enterprise. However even the treatment of the randomised controlled trial as the gold-standard of reliable scientific research is by no means uncontested (Midgley, 2004), and has been labelled 'nostalgia for a simple and ordered universe of science that never was' (Popkewitz, 2004, p.62). Although large scale experimental studies are widely viewed as the most reliable methods for distinguishing the effectiveness of therapy, it has been argued that their very emphasis on de-individualisation and de-contextualisation of complex human

experience make them inadequate tools for investigating the therapeutic process (Cooper, 2011). In contrast, qualitative techniques enable the researcher to acknowledge and privilege complexity and subjectivity in gathering data and constructing knowledge. Thus, while qualitative research is still somewhat undervalued, its capacity for engaging meaningfully with the messy and confusing 'swampy lowlands' of professional practice (Schon, 1995, p.28) makes it a good fit for the clinician-researcher striving to contribute to research knowledge while remaining connected to the subjectivity and ambiguity of the psychotherapeutic encounter (Fonagy, 2009).

Analytic tools

Qualitative research is an umbrella term, rather than a homogenous set of ideas (Midgley, 2006). As noted above, the choice of a particular qualitative methodology is informed by the ontological and epistemological perspective of the research. My understanding of language as constructive social performance informed my decision to use discourse analysis to pursue my research question.

Discourse analysis

Discourse analysis is informed by a number of overlapping intellectual and research disciplines. These include speech act theory, which highlights the centrality of social context to language use, ethnomethodology, which privileges the use of language in making sense of everyday social life, and semiology, which holds that underlying systems of linguistic rules produce and negotiate experience and behaviour (Potter and Wetherell, 1987). Conversation analysis's focus on the negotiation of meaning in ordinary interactive talk is also an important influence on discourse analysis (Willig, 2001). The shared emphasis in these disciplines on the performative and social nature of language is at the heart of discourse analysis's understanding of language as the infinitely malleable building blocks with which we construct reality. Discourse analysis is therefore an appropriate tool for studying the variations in people's accounts of a subject; its anti-cognitivist stance means that it is concerned not with understanding what people really think or mean, but with how language is constructed and the consequences of these constructions. Although discourse analysis treats all language as constructive, and never merely descriptive, it does not necessarily follow that these constructions are deliberate. Rather, using language to constructively achieve social

functions is viewed as intrinsic to everyday speech, and understood as happening both intentionally and unselfconsciously (Potter and Wetherell, 1987).

This research draws on two central, although separate, strands of discourse analysis. Discursive psychology (DP) is concerned with the social and interpersonal objectives fulfilled by discourse practices. DP's treatment of discourse as oriented towards context and used to accomplish social functions makes it particularly well suited to investigating contradictions or variability within people's accounts (Willig, 2001). It does this by paying close attention both to the rhetorical strategies and devices employed when depicting attitudes, and to the style and manner of the descriptive language used in an account. This means the analyst must study the type of vocabulary used as well as stylistic features such as metaphors, hyperbole and grammatical structure. Other non-linguistic aspects of the account, such as tone of voice and hesitations, are also relevant in analysing interview data. So too are the interviewer's own utterances, which are important contextual factors impacting participants' discursive constructions. Wetherell and Potter (1992) use the term 'interpretative repertoires' to describe clusters of specific terms, descriptions, idioms and grammatical features that are drawn on by people in talk to construct different versions of themselves, others, actions and events.

DP has two major, overlapping preoccupations: the action and epistemological orientations of talk. Action orientation refers to the ways language is used to achieve particular effects, such as attributing blame or disclaiming responsibility. DP understands the use of rhetoric as extending beyond formally or explicitly argumentative contexts. Instead rhetoric is seen as 'a pervasive feature of the way people act and arrive at understanding' (Potter, 1996, p.106). People's expressions of attitudes are therefore reformulated, not as reflecting de-contextualised cognitions about the world, but as always implicitly or explicitly countering potential alternatives (Wetherell and Potter, 1992). Attention is paid to the speaker's management of stake or interest in a given account, for example by actively disclaiming interest in presenting an account in a particular way, or by using stake inoculation to counter potential accusations of personal interest in taking up a particular position. Action orientation is also concerned with how descriptive language is used to construct an object or event. For example detailed description or active voicing may be used to vividly bring to life a particular version of events, while placing a broad gloss on the details of an account

may function to prevent too detailed an inspection of its factuality. The epistemological orientation of talk refers to the ways in which a particular account is designed to come across as accepted fact. Specifically this takes in the manner in which the describer's identity is constructed as authoritative or trustworthy and the strategies used to build up their neutrality in relation to the subject under discussion. Witness consensus may be invoked to demonstrate the accepted nature of the speaker's version of events, or the speaker themselves may highlight their status as witness to events to demonstrate their epistemic authority over the hearer. It should be noted that the division between action and epistemological orientations is a artificial one as these two orientation constantly intersect and interact; actions are achieved through fact construction, and facts are constructed using rhetorical strategies which attribute or disclaim blame (Potter, 1996).

Foucauldian discourse analysis (FDA) interrogates the discursive resources available to people and the broader subjective and practical implications of these discursive parameters (Willig, 2001). Wetherell and Potter (1992) describe Foucault as a 'historian of science' (p.79), but they are careful to point out that this description is insufficient, as it does not capture Foucault's primary preoccupation with how knowledge is constituted through discursive formations, and the vicissitudes of power that are mobilised as a result. Foucault's anti-essentialist and anti-hermeneutic stance does away with the search for 'real' meanings and focuses instead on the process of truth creation: how certain discourses become recognised as 'truth' at certain times in certain places. Truth in Foucault's terms, therefore, is 'powerful knowledge' (Wetherell and Potter, 1992, p.81), and his interest is in uncovering not who wields or is coerced by power, but what subjects, objects, social structures and actions are created and driven by powerful discourse.

In charting the dynamics of power, Foucault distinguishes between the concept of power as a repressive, coercive force, which he labels 'sovereign power', and what he calls 'disciplinary power' (Dreyfus and Rabinow, 1982, pp.134-135). Disciplinary power is 'productive', in the sense that it treats human subjects as 'docile' bodies who can be usefully put to work in the creation and maintenance of social institutions (Ibid.). Disciplinary power is not readily visible, at least not as a repressive force. Rather it suffuses social institutions and practices, and, as Foucault (1980) explains, 'Its success is proportional to its ability to hide its own mechanisms' (p.86). The reliance of

disciplinary power on normalization, in which it works by defining the boundaries of the expectable and the acceptable in society means that 'resistance to some domination frequently occurs within the terrain already set, and through the very agenda which shapes the domination' (Wetherell and Potter, 1992, p.84). FDA's concern with the capacity for discourse to inform and delimit particular 'ways-of-being and ways-of-seeing' (Willig, 2001, p.107) makes it a suitable tool for interrogating the role of discourse in legitimating particular social processes or maintaining power relations.

The overlaps and divergences between DP and FDA are the subject of ongoing debate, in which DP's concern with micro-analysis of talk and its everyday functions is sometimes held to be incompatible with FDA's preoccupation with the genealogical context of discourse and the dynamics of power that create and are created by it. However this theoretical division has been argued to be an artificial one, and an eclectic approach in which each analytic frame is read 'in terms of the other' has been recommended (Wetherell, 1998, p.388). In line with this, following an initial thematic analysis, my data analysis took place on both micro and meso levels. Using DP, a fine-grained analysis of interviewees' accounts of the research subject paid attention to the management of stake and interest in conversations about combining psychoanalytic and medical models of ADHD, and identified interpretative repertoires drawn on by participants when talking about their work with children medicated for ADHD. Using the overarching metaphor of a partnership that is only ostensibly well-functioning, this analysis drew attention to participants positioning of themselves along a spectrum of acceptance of and resistance to the use of medication alongside psychotherapy. FDA then enabled exploration of links between the use of these repertoires and broader social, political and historical discourses of child mental health, scientific knowledge and blame. It is important to point out that the aim of this study was not to debunk or to prove the validity or trustworthiness of one or another approach to ADHD. Rather, following Foucault, it sought to suspend judgment about these issues, and instead to explicate how knowledge and practice are constituted through discursive formations (Wetherell and Potter, 1992).

Research methods

I now turn to a description of the process of gathering, analysing and presenting my data. Since there is very little empirical literature on the practice of conducting

psychotherapy with children medicated for ADHD, I approached this subject inductively, striving to be lead by the data rather than by a particular theoretical or analytic interest or perspective. However as Charmaz (2008) notes, it is impossible to approach any subject free from epistemological or disciplinary assumptions, and researchers frequently have 'an intimate familiarity with the research topic' (p.85). I therefore followed Coffey and Atkinson (1996, p.157) in differentiating between 'empty-mindedness' and open-mindedness, by actively reflecting on the ways in which my own clinical and training experiences, as well as the existing literature, sensitised me to ask certain questions and pursue certain ideas. Throughout the research process I kept a reflective journal, which enabled me to expand on and deepen my understanding of the assumptions I brought with me to the project. In the following account of the research process I will discuss the ways in which I was compelled to acknowledge and question the some of the beliefs and ideas with which I came to the research. I also describe how in turn my data and findings led me to re-evaluate aspects of my chosen methods, and to consider the constructive and action-orientated nature of my own discourse. As well as being woven throughout this section, the reflexive process is embedded into the thematic analysis, which is detailed at the beginning of Chapter Four. This demonstrates how reflections on the interactive research process informed the outcome of this study.

Identifying data sources

I chose to investigate the research subject using semi-structured interviews with child psychotherapists. Potential alternative data sources were psychotherapists' process notes from sessions with medicated children, or case studies of treatments of children who were medicated for ADHD. I ruled out process notes because obtaining and using confidential clinical notes raised ethical issues that were beyond the scope of this time-limited doctoral research. Since I originally approached this study intending to theorise about child psychotherapists' experiences of their work with medicated children, rather than about their ways of talking about it, I excluded published case studies because they are explicitly processed and edited for the purpose of an academic and/or clinical audience. However the 'turn to language' (Willig, 2001, p.102) provoked by my experience of beginning to analyse the data meant that later in the research process I began to treat all texts as processed and filtered for the benefit of some form of audience. On reflection I believe case studies therefore could have been a useful data source for a discursive investigation of this area. However, by paying close attention to

the ways I positioned myself and was positioned by participants during our interactions and conversations, I found that the interview process itself raised salient issues relating to the intended audience for this particular type of talk. This will be discussed in detail later in this section, as well as in the discussion of the thematic analysis in Chapter Four.

Recruiting participants

When looking for participants I used non-probability sampling, seeking to identify individuals with experience relevant to the topic under investigation, rather than attempting to achieve a random or representative sample (Mays and Pope, 1995). Accordingly, I recruited interviewees by email invitation via the mailing list for the Association of Child Psychotherapists. This ensured that although there may have been some variation in respondents' individual theoretical perspectives, they were all trained and qualified in a psychoanalytic model. In the email I gave a brief outline of the area I wished to study and explained that I hoped to interview qualified psychoanalytic child psychotherapists, with experience of conducting psychoanalytic psychotherapy with children aged between five and 12 years, who were medicated for ADHD⁸. Unlike in quantitative research, in which large sample sizes are required to lend statistical power, in qualitative studies too many participants can compromise the sensitivity and intensity of the analytic process (McLeod, 1999). I therefore selected six participants with the aim of conducting and analysing in-depth interviews with each of them. All the participants were female (I will return to this issue in the conclusion in Chapter Six). For a breakdown of participants' years of professional experience and clinical settings, please see Table 1.

Interview procedure

Before sending out the call for participants, I obtained ethical approval from the Department of Psychosocial Studies at Birkbeck College (see Appendix 1). Prior to each interview participants were provided with an information sheet detailing the aims of the study, as well as written and verbal guidance on maintaining anonymity and confidentiality (see Appendix 2). This reminded them that they must not reveal names or identifying information when discussing their clinical work. Each interviewee signed

⁸ I chose these age criteria because NICE guidance (2013) does not recommend medication for children under the age of five.

Participant	Years since qualification	Clinical setting
Deborah	28	NHS specialist school/private
Karen	14	NHS CAMHS/private
Amanda	15	NHS Looked-After Children team
Olivia	2	NHS funded post in voluntary sector setting
Jenny	6	Private residential children's home
Rita	6	NHS complex needs team/private

Table 1. Participant information

two consent forms explaining confidentiality and the right to withdraw, keeping one for their records (see Appendix 3). Before beginning recording I reminded the participants of the purpose of the interview and gave them time to read the information sheet and sign the consent form. I also discussed confidentiality and the participant's right to withdraw from the project at any point. To maintain confidentiality participants' identities were anonymised on the recordings, transcriptions and in the final presentation of the study and data. Their identifying information was only recorded where necessary, was kept separate from the data and was only accessible to me and to my supervisors. The interview recordings and transcripts will be destroyed following the final submission of this doctorate.

Although this study aimed to explore in depth psychotherapists' professional and personal experiences of their work, the research area is not explicitly concerned with private life experiences of the participants. Although personal, sometimes distressing, emotional responses are used in psychoanalytic treatment and were therefore likely to form part of the interview material, as qualified child psychotherapists the interviewees had all undergone or may still have been undergoing personal psychoanalysis to assist them in managing this aspect of their work. They were also likely to have access to professional support networks. Thus, the risk that the material

discussed would become overwhelming or cause unmanageable distress to interviewees was low. However, it is always possible that the data collection process may inadvertently cause distress. To prepare for this eventuality, a support service was available through my training school, the British Psychotherapy Foundation, to which participants could be referred if necessary. Fortunately this was not needed at any point in the study.

Early on in the recruitment process, I discovered that since I had recruited interviewees through their professional organization, NHS ethical approval was not required to interview them about their experiences of work that took place in their NHS settings (see Appendix 4). Previously I had believed that I could not obtain ethical approval to interview child psychotherapists directly about their NHS work without going through a lengthy NHS ethical approval process, which was unrealistic within the time frame for my research. In discussion in research seminars it was suggested that this difficulty could be surmounted by interviewing child psychotherapists who did both private and NHS work, on the proviso that they did not identify in what setting their work took place during the interview. As a result, my first two participants were chosen due to their experience of working with medicated children in both private and NHS settings. By the time I began the interviews I had confirmed that participants could talk freely about their work in both NHS and non-NHS settings. However, in retrospect my own experience of planning to access participants' experiences NHS work 'under the radar' placed both myself and the interviewees in an awkward relationship to thinking and talking about work in the multidisciplinary NHS setting, in the sense that we were interested or involved in it, but unable to freely or easily engage with it. This awkwardness was also reflected in my experience of the interview settings. Due to geographical and timing considerations, I interviewed all the participants either in their private consulting rooms or their homes, rather than their clinics. The quiet, ordered, often somewhat luxurious-feeling surroundings presented a marked counterpoint to participants' descriptions of frenetic clinic life, in which children diagnosed with ADHD repeatedly fled or damaged the therapy room and endangered themselves or others. These preliminary struggles with integrating different aspects of this work seemed to foreshadow aspects of the thematic analysis that captured the dissonances between theory and practice of working with children with ADHD. The image of the sedate, calm consulting room juxtaposed with the overwhelmed clinic returned to me later when I developed the theme of *communication breakdown* to encapsulate my sense of the

process of researching the subject of psychotherapy with children medicated for ADHD.

Using my own clinical experiences as 'points of departure' (Charmaz 2008, p.85) I prepared a set of open-ended questions about child psychotherapists' experiences of working with children medicated for ADHD (see Appendix 5). These questions aimed to facilitate a conversational style and to allow unanticipated areas to emerge and be explored. During the first two interviews I occasionally found myself using language that positioned me more as a child psychotherapy trainee or colleague than as a researcher. Following these interviews I wondered if at times this had lead me to take for granted some of the participants' responses, rather than probing them more deeply, eliciting 'professional' responses, and diminishing access to participants' rich, personal or esoteric accounts of their experiences. I addressed this in subsequent interviews by making explicit the difference between my role as a researcher and as a clinician, emphasising that I might ask the interviewee to tease out ideas that seem obvious to them. This enabled me to have greater confidence in taking a more open, naïve stance, which helped take conversations beyond the 'public relations viewpoint' (Charmaz 2008, p.88). However, the subsequent data analysis provided an additional lens through which to view these early ruptures to my attempts to maintain my researcher stance, by bringing into focus the issues of authority and legitimacy raised by the research process. In the following extract from my first interview, with Deborah, I step out of my researcher role and position myself more as an eager colleague or supervisee:

- D: *I mean, ME, chronic fatigue syndrome, you know, which again I've got a lot of questions about those, um, you know, so you've got the sort of, you know, you've got the question again sort of if somebody were receiving, I don't know what one would receive in, in terms of those sorts of things but if there was some medication would one think well that's great, you know. The body will get a boost and then we can think about actually what got this person to this state.*
- S: *Hmm.*
- D: *Or you know, they don't have to be exclusive I don't think.*
- S: *Hmm.*
- D: *Um, and certainly you know, once one gets into, to things that, that's clearly displayed themselves in the body, you know, I think having the body helped is, you know, only to the good.*
- S: *Hmm. That's an interesting sort of comparison really because I suppose ADHD is sort of on the line between, I mean well, who knows where it is but you could see it, or perhaps people would like to see it as a physical illness, a brain illness, and so, and actually it has very physical manifestations. So I suppose if you're thinking*

that the, the actual, the body can be helped to be calm, in order to make use of kind of thinking

D: Yes.

S: *then that's a sort of useful comparison.*

D: Hmm.

My assenting, enthusiastic stance in this interview precipitates a role reversal in which I begin expounding on ideas about the research area, and the interviewee responds with encouraging sounds. This deviation from good interview technique interfered with the flow of Deborah's responses, failing to elicit additional comments and in fact closing down the exchange. Closer reflection on what may have precipitated this failure to maintain a reasonably neutral interviewing stance deepened my understanding of the impact of the social context in which the interview data was produced. As a trainee child psychotherapist interviewing older, more experienced qualified members I positioned myself as an enthusiastic, knowledgeable and amenable younger colleague, keen to both fit in with and contribute to the profession. In turn, the participants were supportive and encouraging of my research endeavour, conveying approval of my investigation of this under-researched but important area, and showing an interest in how and when I would analyse and present my findings. In this way my research and I were positioned as potentially influential on the ways in which child psychotherapy is viewed in relation to this field. As such, our discursive performance can be understood as taking place on a social stage in front of an audience of clinicians and researchers interested in this field, and therefore intended at least in part for this audience. The implications of this are discussed in more detail in the discussion of the thematic analysis in Chapter Four (pp.52-53).

Initial data analysis

Thematic analysis is a qualitative research method that can both organise and interpret data (Braun and Clarke, 2006). Its flexibility makes it particularly well-suited to preliminary research investigations of under-theorised areas. My initial thematic analysis involved coding the data inductively in order to produce a thematic map of the whole data set. In the following sub-sections the thematic analysis is described as a step-by-step process.

Initial coding (Appendices 6 and 7)

To facilitate maximum immersion in the data, where possible I transcribed the interview recordings myself; however time limitations meant that four out of six interviews were professionally transcribed (see Appendix 6 for transcription key). Following transcription, I read each interview transcript twice, to gain familiarity with the text and to get a feel of the atmosphere of each conversation. I engaged in this reading actively, reading once out loud, and recording initial ideas as I read through each transcript. After this preliminary stage, for each interview I began descriptively labelling units of text that were meaningful to the research topic. Next I organised these descriptive units into thematic groups that formed the initial codes for each interview. Data extracts that were relevant to more than one code were coded multiple times. The final stage of initial coding was to group together the descriptive initial codes that overlapped or shared central features to develop conceptual categories. These were developed for each interview and named 'researcher categories'. To ensure the analysis remained grounded in the data, initial codes and researcher categories were organised in tables, which linked them to the original text extracts from which they were developed (for example see Appendix 7). To guard against loss of context, I was careful to keep some the surrounding text for each extract. This was helpful when revising codes and themes throughout the analytic process, allowing me to constantly revisit the raw data when refining themes.

Data set coding: Developing initial themes (Appendices 8 and 9)

After each interview had been coded to develop researcher categories, these categories were collated, and duplicates were noted and merged if appropriate. The categories were then revisited, along with the relevant data extracts, in order to identify connections, relationships and patterns between them. At this stage I also began memo writing. This entails the development of categories into narrative form, by elaborating processes, actions and assumptions. Memos are written quickly, without editing, in order to preserve the natural, human element to the thought processes that are being elucidated (Charmaz, 2008). Writing memos helped me to elucidate categories and consider how they might combine to produce a broader theme (for examples see Appendix 8). At the end of this stage, the categories were grouped together and synthesised into 11 initial themes (see Appendix 9).

Theme and data review: Finalising central themes (Appendix 10)

The final analytic stage involved returning to the data extracts once more to test whether they cohered within their thematic groupings. At this stage it became clear that several of the themes overlapped to such an extent that they could be collapsed into new single themes at a higher level of abstraction. For example, 'Competition' and 'Disempowerment' were merged to form *Inequality*. 'Struggles with voicing criticism', 'Disavowal of expertise' and elements of 'Difficulties linking treatments' were combined to form *Ambivalence/uncertainty*. 'ADHD as defence' and 'ADHD as relational' were amalgamated into *Meaningful communications*. It also became clear that 'Compatibility' could be subsumed under *Approval/acceptance*. On revisiting the theme 'Environmental complexity' I realised that it had remained largely on a descriptive level. By going back to the data extracts and categories associated with it, I was able to develop the more conceptual theme, *An alternative position*, with 'Environmental complexity' becoming a sub-theme. Similarly, although 'Difficulty linking treatments' was supported by much relevant data, it too had remained descriptive rather than conceptual. Some aspects of this initial theme were important in forming the central theme *Ambivalence/uncertainty*, while others combined with reflections on the research process to create the central theme *Communication breakdown*. Finally, in reviewing 'Theory versus practice' it became clear that this was in fact a sub-theme running through *Approval/acceptance*, *Ambivalence/uncertainty* and *Communication breakdown*. At the end of this stage, the thematic analysis was concluded with six central themes (see Appendix 10).

Central themes

The six central themes produced by the thematic analysis can be summarised as follows:

1. *Acceptance/approval*: This relates to explicit messages of support for the use of medication in helping children engage with psychotherapy or with other aspects of their lives.
2. *Ambivalence/uncertainty*: This denotes contradictory or doubtful ways of talking about the role of medication, often including disavowals of expertise in this area or critical views accompanied by disclaimers.

3. ***Inequality***: This refers to participants' depiction of themselves as the disadvantaged partner when working alongside those prescribing medication.
4. ***Meaningful communications***: This encapsulates child psychotherapists' understanding of ADHD symptoms as expressions of painful or dangerous thoughts or feelings, which should be understood rather than eliminated.
5. ***An alternative position***: This entails child psychotherapists' presentation of themselves as attempting to resist collusion with the location of pathology solely in the child.
6. ***Communication breakdown***: This refers to the elusiveness of the subject of medication throughout the research process and the conversational dead ends engendered by this.

The threading of the sub-theme 'Theory versus practice' through several of the central themes was an important feature of the thematic analysis. This sub-theme refers to differences between participants' descriptions of their theoretical beliefs about combining psychotherapy and medication, and their descriptions of their clinical experiences. The former tended to be supportive and positive, while the latter tended to disregard or portray an uncertain attitude towards medication. These incongruences and contradictions were also mirrored in the tensions between the themes, and in my experience of the research process. Within the same interview, and sometimes within the same sentence, both support for and rejection of the use of medication could be identified. The model of ADHD espoused by the interviewees often presented many challenges to a medical approach, yet these challenges were rarely acknowledged. Child psychotherapists were portrayed as both active and successful therapists for children diagnosed with ADHD, and uncertain newcomers to the field. It seemed to me that these initial findings were suffused by unspoken conflict and discomfort, for which the thematic analysis was an insufficient tool. For this reason, a further layer of discourse analysis was required to pay attention to the 'stresses and variations' in the interview material, and to grapple with its performative aspects (Wetherell and Potter, 1992, p.61). In the next section therefore, following an in-depth discussion of each of the central themes, I describe further the process of my 'turn to language' (Willig, 2001, p.102), and present in detail the first stage of the discourse analysis.

Chapter Four: Data Analysis I

Introduction

So he'd say something like, you know, 'I think, the medication's going fine', or something, but you'd feel it was a bit like hearing him repeat something he'd heard. Rather than something he was really thinking, that was connected with a bit of him.

I have chosen to open this section with the above excerpt from my interview with Olivia because it encapsulates a struggle with engaging with the subject of medication that characterised the process of this research. Like Olivia's patient, the child psychotherapists who agreed to be interviewed for this project made many positive statements of acceptance and approval of the use of medication alongside psychotherapy. Yet the impact of medication was largely absent from their descriptions of their clinical work or their ways of thinking about their patients. In fact, during the interviews, retaining focus on the subject of the role of medication in participants' work was extremely difficult, and direct questions about medication often provoked answers suffused with uncertainty and ambivalence. The initial thematic analysis produced the six themes summarised at the end of the previous chapter. Below I discuss each of these in detail, before going on to describe the additional discourse analysis carried out to make further sense of these findings.

Thematic analysis

The theme ***Acceptance/approval*** refers to participants' expressions of support for the use of medication. An example of this is Deborah's description of her experience of offering psychotherapy alongside medication, as follows:

D: *I think there was certainly a feeling when I worked at X unit⁹, if I'm allowed to talk about my NHS work¹⁰, that there was something, you know, that, that the Ritalin sort of gave you a window of opportunity. It gave you a sort of, a calm*

⁹ Deborah had worked at a specialist educational unit for children with emotional and behavioural difficulties

¹⁰ As discussed in the previous chapter, it was initially unclear whether I could discuss participants' NHS work without obtaining ethical approval from each of their NHS Trusts. At the beginning of this interview I let Deborah know that I had confirmed that because I had recruited her and my other participants through their professional body, formal NHS ethical approval was not necessary, providing participants did not reveal any identifying information about the children they discussed.

space to be able to do some thinking whereas without it perhaps there wasn't that calm space. At all.

Deborah characterises the medication as working to support psychotherapy by improving the child's capacity to engage in the '*thinking*' work, which is central to the therapeutic endeavour. Ritalin here is a helpful adjunct to the therapy, an important gift without which psychotherapy may not have been able to progress. It is notable however that Deborah frames this attitude towards medication as a '*feeling*', highlighting the subjective nature of this interpretation of events.

The theme **Ambivalence/uncertainty** captures this ambiguity, which pervaded much of the interview material. This is exemplified by Olivia's reflections on the role of the medication in her four-year treatment of a young boy:

O: *I'm not in a position to know, I don't know what it would've been like, we weren't monitoring it. We weren't tracking the performance and after and all the in-betweens. And what would it have been like without it? Who knows? Don't know. My sort of suspicion is that it wouldn't have been much different. It would've been, might've been different at home, you know, that might've been- and at school.*

Olivia disclaims knowledge about the impact of medication, appealing to the absence of a systematic method of investigating this. Her rhetorical questions convey a sense of addressing an unanswerable question. When Olivia does voice her '*suspicion*', that medication was ineffective and unimportant to the treatment, she immediately balances this with the possibility that others settings or observations would provide a different perspective. This ambivalence and uncertainty was common when critical views of medication were expressed, resulting in an impression of participants oscillating between different attitudes.

The following extract from my conversation with Rita illustrates the theme **Inequality**. She is talking about offering colleagues a psychoanalytic perspective on children diagnosed with ADHD:

R: *Oh, it's lately extremely difficult. It was easier, but budgets are so limited now. And I think unfortunately, um, there's also a lot of demand, much more than it was probably, maybe, I don't know the services are cut down.*
S: *A lot of demand so a lot more referrals?*
R: *Yeah and there's not enough, uh, empirical work to show that psychotherapy helps these children so the clarity is lost. Uh, there is a lot of maybe work done by*

the medical companies. Um, you know, they sort of have the say more in these children's future unfortunately.

S: *So it's hard to make a case for therapeutic input?*

R: *Yeah.*

S: *And you're putting that down to, um, declining resources and also medical companies advertising and?*

R: *Yeah, NHS is taking money away from talking cure basically, yeah. So hopefully research like yours will help these kids!*

Rita's presentation of the twin pressures of reduced funding and increased referrals as restricting the voice of child psychotherapy confers a sense of competition for both resources and authority. The child psychotherapist is constructed as limited in their capacity for competing with the financial and scientific clout behind medical interventions. Rita portrays her profession as marginalised, and needing to find a way to balance the scales. Rita's interpretation of my research as potentially functioning to redress this balance is key, in that it alerts us to the performative nature of the interview material. Here, for example, Rita portrays me as someone with the capacity to improve children's access to psychotherapy by giving child psychotherapists an authoritative voice ratified by research. This will be discussed in more depth later in this section (pp.52-53), as well as in the critical reflections on research in Chapter Six (pp.100-101)

The theme ***Meaningful communications*** speaks to interviewees' formulation of hyperactive, inattentive and impulsive behaviour as linked to feelings of distress that the child is unable to express verbally or in other ways. ADHD symptoms were understood as developing in the context of deficient or traumatic early experiences. These environmental factors were understood as having the potential to impede the child's capacity for emotional self-regulation, symbolisation and for developing and experiencing empathic relationships with others. In the following extract, Jenny describes her experience of being with children diagnosed with and medicated for ADHD:

J: *Usually I feel, you know, great pathos or I, I'm in touch with some aspect of their despair, um, you know their manic behaviour can sometimes, like somehow I get the despair that runs underneath it, um. Um, that's usually. And the longing really, you know the longing to, to reach out to somebody despite the terror of doing so, you know, I feel that tension and the longing and the fear.*

Here Jenny constructs ‘*manic behaviour*’ as the surface manifestation of deep sadness. She also highlights her understanding of her patients’ behaviour as linked to relational difficulties, specifically the yearning to make contact with others alongside the paradoxical fear evoked by doing so. In locating hyperactive behaviour in the context of the need to be able to safely make use of intimate relationships, Jenny, along with all the other interviewees, locates ADHD within an attachment framework. This had implications for interviewees’ construction of the sort of help needed by these children. Olivia demonstrated her understanding of the child’s relational experiences and capacities as being the target of intervention when she reflected:

O: *I think he needed an emotional experience with someone and he needed it to be a real one.*

The development of an authentic relationship with the child was understood in several accounts as a crucial pre-requisite to more traditional psychoanalytic interventions such as interpretation. Several participants’ reflected on the impact of their patients’ overactivity on the therapeutic process, and the need to adapt technique in order to manage this, for example with an extended period of building a trusting relationship. Although as seen in ***Acceptance/approval***, medication was presented as theoretically helpful in this area, in their recollections of clinical work, participants did not portray medication as playing a role in combating ADHD symptoms or facilitating the therapeutic relationship. This is exemplified by an extract from my conversation with Laura, in which she is explaining why she makes use of tapping and meditation techniques to help calm her patients at the beginning of sessions:

- L: *I I I’ve got, I’m thinking of three kids, who who literally are, you know, cartwheeling, somersaulting, off the walls and that in the in the room, if I don’t do something, and, I I can’t work like that. I don’t know whether they’re hearing anything, but I can’t work like that [laughing], it dysregulates me to such an extent.*
- S: *Right, ok*
- L: *That I can’t work like that [laughing]. Can’t say anything else!*
- S: *Right, so that’s a little bit about your experience of being in the room with a child. Are are you speaking, are those three children that you’re thinking of, are any of them on medication, or are they all diagnosed with ADHD but not on medication?*
- L: *Yeah, all three of those that I was talking about then are on medication as well so...not sure what it’s doing [laughing].*

Although elsewhere in the interview Laura had expressed her support for the use of medication to help children access psychotherapy, her reports of clinical experience

contradicted this view. Indeed all participants underlined the potential value of medication in helping children access psychotherapy, but reports of its impact were almost always restricted to settings other than the therapeutic one:

- O: *[Medication] might've been very helpful in those places where actually you're not, you know, you do want to have some form of helping the child regulate their behaviour, whereas in therapy, that's not what I was there for.*

Without explicitly acknowledging any conflict between the two treatment models, Olivia's comment highlights differences between medical and psychotherapeutic approaches to ADHD: Medication aims to improve behaviour, while this is not a primary goal of the psychotherapeutic process. Olivia's carefulness not to detract from medication's potential helpfulness when voicing this suggests some caution about approaching the subject of differences between the two approaches.

The theme ***An alternative position*** entails expressions of implicit resistance to prevailing ways of managing or thinking about children diagnosed with ADHD. Rita describes her use of supervision to help process her despair and anxiety when working with children displaying hyperactive behaviour:

- R: *So you start thinking differently and getting out of that role. That helps the child, a lot of them I think...because a lot of the time our environment talks quite, you know, in negative terms about these children. They have very limited expectations. So these children really, if they see in your eyes that you care and you really like them, that helps them.*

Here resisting dominant attitudes towards the child is portrayed as an essential part of the therapeutic process. The decision to offer both psychotherapy and medication was presented by several participants as driven by anxiety in the system in the context of some sort of crisis, such as the threat of a school expulsion or a foster care placement breakdown. This is exemplified when Olivia explains how a child referred to her came to receive both psychotherapy and medication:

- O: *The reason why he got that sudden sort of drawing together of resources was because he was in a state of crisis. And his placements were very much at risk. So there was a sense of alarm, emergency, about trying to address his very difficult behaviour. And that, you know, suddenly where there hadn't been anybody doing anything very much, resources became available and everybody started acting in a rather uncoordinated way.*

By drawing attention to the anxiety-driven, disorganised aspects of intervening with her patient, Olivia distances herself from this reactivity to crises. Adopting a thoughtful, circumspect attitude to children presenting risky or dangerous behaviours was a common theme, in which participants portrayed their role as attempting to tolerate and understand children's difficult and painful feelings. This often involved making links to systemic factors that could be impacting the child's behaviour, as well as the decision to offer them medication. Karen described part of her role helping other professionals resist the '*tendency for...fight or flight*', for example by avoiding difficult network meetings which aim to bring together the various environmental factors impacting on the child. Karen's resistance to the atomising effect of the focus on diagnosis is conveyed when she describes her attempts to '*keep things as a whole really...Rather than, you know, divide them up, learning disability, or you've got, you know, ADHD, you know.*' While participants rarely explicitly criticised the practice of medicating children, they also presented their way of working as resisting the de-contextualisation of the child's difficulties by locating the problem solely in the child. This is exemplified by a further extract from Rita, in which she constructs the use of medication as a tool to support overwhelmed carers:

R: *I mean sometimes parents are in very difficult situations, so schools, social workers, they do demand medication because the child seems impossible in those settings...it's just making the child a bit more manageable for drained parents or school to keep the child.*

Thus, the theme *An alternative position* encapsulates child psychotherapists' paradoxical presentation of themselves as resisting the anxiety-led and pathologising aspects of diagnosis and medication, without explicitly rejecting or criticising these practices.

The final theme produced by the initial thematic analysis is **Communication breakdown**. This theme emerged largely from my analysis of the interview process and my reflections on the experience of talking to participants about the subject of combining psychotherapy and medication. I used my reflective journal to begin grappling with the difficulties I encountered when trying to elicit participants' views about or experiences of their work with children on medication. Following my third interview, with Laura, I wrote:

The interviews easily drift into talking about children who are not medicated or do not have ADHD and we seem to have trouble staying with the subject. Often answers about medication are short and seem to close down the conversation.

Later, after I had completed and analysed the fifth and sixth interviews with Jenny and Rita, I reflected further on why it had felt so difficult to bring together the subjects of psychotherapy and medication:

There was a particular feeling in both interviews of creating an abrupt shift from clinical details into medication when asking about role of medication, which felt very uncomfortable. Like an unwelcome interruption that somehow made me feel 'less of a psychotherapist' to be showing such an interest in medication. Felt 'clunky' as if the two subjects really did not fit together comfortably. Difficulty of staying on subject of medication remains – both participants (like previous ones) seem to find it much easier to talk about therapy or medication, not both. It was hard to stay away from tangents into descriptions of work with children with ADHD but not on medication. I found myself constantly clarifying whether this child was on medication or not, then feeling some anxiety and awkwardness about asking, as if I am constantly dragging us back to a subject that is not relevant.

These reflections forced me to acknowledge and question the assumption that it is desirable or possible for pharmacological and psychotherapeutic interventions to be thought about together. Although this assumption was ostensibly reinforced in participants' explicit accounts of their support for combining the two approaches, and in their enthusiasm for taking part in the research, it was also often undermined by the process and feel of the interviews, in which attempts to explore the combination of psychotherapy and medication seemed to engender a **Communication breakdown**.

I have tried to show how the story of my initial analysis of the interview data is one of a struggle with contradictions, between explicit messages of acceptance of the use of medication alongside psychotherapy, and implicit communications of uncertainty and resistance to this practice. Engaging with these puzzling contradictions necessitated a shift from examining what participants said, to studying *how* they said it, and *who* they said it *for*. Reflecting on my own contribution to the construction of meaning about this subject was central to this endeavour. When I began this research, I was a trainee child psychotherapist at the beginning of my training, part of only the second cohort at my training school to undertake a clinical doctorate. Interviewing qualified, often very experienced, senior colleagues was a challenging process, which brought to the fore issues of authority, permission and entitlement to openly express opinions. I recorded in my journal that the interview with Laura had felt '*combative*', and reflected:

This interview awakened concerns in me about how to think and write honestly about some of my ideas about what happens in interviews – professional relationships, loyalties and hierarchies feel as if they will get in the way. This must also intrude on participants and their capacity to say what they want to say. Interestingly this began to be acknowledged openly at the end of this interview, when Laura talked about her dislike of a psychiatric colleague, and expressed her uncertainty about whether it was ok to express these ideas.

The possibility that opinions expressed will be critically scrutinised seemed to hover over the research process. I noted how Jenny had voiced concern that she had not 'prepared' adequately for our interview, and had been reticent about being recorded. Her anxiety about the interview further alerted me to the question of what audience participants might imagine examining and judging their views about or experiences of this work, and how this might impact what they said and how they said it. I was carrying out these interviews at a time of professional insecurity, particularly for child psychotherapists working in an increasingly stretched NHS, and of growing pressure on child psychotherapists to demonstrate their legitimacy and the efficacy of their work. The assumption that active engagement with the medical approach to ADHD is valuable was evident in participants' enthusiastic attitudes to the study. Almost all the interviewees complimented me on undertaking research in an area they saw as 'important' (Karen). Furthermore, several expressed an interest in how I would be 'scoring' the interviews (Laura), or when I would have the 'results' (Rita). Rita's optimistic comment that 'hopefully research like yours will help these kids' (who she believes need psychotherapy but do not receive it), constructs the research endeavour as an attempt to halt the erosion of the role of child psychotherapy within the NHS. Participants' concern with the results, presentation and impact of the research process speaks to their perception of the research endeavour as having the potential to communicate trustworthy, empirical findings to a wider audience outside child psychotherapy. These formulations necessitated my turn to the tools of discourse analysis to probe more deeply the performative elements of the interview material and to explore what versions of reality were constructed through participants' ways of talking about the research subject.

Discourse analysis: Interpretative repertoires

The discourse analysis draws on the metaphor of a marriage that is only superficially well-functioning to reflect the double messages identified throughout the interview material. Participants' explicit support for and implicit resistance to the combination of medication and psychotherapy is understood as fuelled by 'a dilemma of stake or interest' (Wetherell and Potter, 1992, p.97), in which the expression of openly critical views on the use of medication was felt to be potentially sensitive or problematic. This dilemma is managed through the use of three interpretative repertoires:

1. **A marriage of convenience**
2. **Separate lives**
3. **For the sake of the children**

These interpretative repertoires capture the co-existence of compliance with and resistance to the use of medication alongside psychotherapy found in participants' accounts. In the first two repertoires interviewees take up positions of ambivalence acceptance, compliance, avoidance and indirect criticism. These positions function to ward off potential accusations of being automatically opposed to or dismissive of the use of medication, while also expressing resistance to aspects of the medical model. In the third repertoire interviewees position themselves as constrained by competing forces in trying to offer help to needy children and families. In the remainder of this chapter, I give detailed examples of each repertoire, and discuss the complex constructions and actions that are achieved through them.

A marriage of convenience

Throughout the interviews participants consistently highlighted the congruity of the aims and functions of psychotherapy and medication, the capacity of medication to help children engage with the therapeutic process, and the helpfulness of effective joint working with prescribing colleagues. Yet in descriptions of clinical experiences, the effects of medication were frequently portrayed as non-existent or undesirable, and contact with prescribers was characterised as minimal or absent. **A marriage of convenience** encapsulates this double message. On the one hand psychotherapy and medication are constructed as compatible, with the potential for working well together.

On the other hand this happy union between the two treatments is portrayed as an unobtainable ideal, or as a political necessity that legitimises the practice of psychotherapy.

When describing the compatibility of the two treatments, interviewees used conditional syntax, underlining the contingent, ideal nature of this compatibility. Failures in effective joining up were reported second-hand, or using vague, abstract language. Differences between the two treatments were minimised, and child psychotherapists' ability to take part in conversations about psychotherapy and about ADHD using the language of research, evidence and the brain were portrayed as bolstering their status and legitimacy in the field. While the explicit message was one of support for combining psychotherapy and medication, the rhetorical devices and language used by participants conveyed ambivalence and tentativeness about the viability of a truly fruitful partnership. By positioning themselves as enthusiastic about collaborating with prescribing colleagues and distancing themselves from overtly critical or challenging attitudes, interviewees warded off potential accusations of preconceived mistrust or dislike of the medical intervention. At the same time the contingent and political flavour of narratives about this partnership communicated doubt about the possibility of a genuinely healthy or happy union. In this way, participants' expressions of engagement and concordance with a medico-neurological model of ADHD can be understood as ambivalent acceptance or superficial compliance in the context of an unequal partnership.

The contrast between theoretical beliefs about the compatibility of the two treatments, and the clinician's actual experience is exemplified in the following extract from my interview with Olivia

- O: *So ideally yes they should be integrated and there should be a lot more dialogue. Um, I mean my, my experience is that they often aren't. And often medication is actually the only um...sustained intervention. I'm not saying that, and I think sometimes there are um, you know, there, there can be some help for the parents, but, or for the child, but actually I, I have seen very little, ah the vast majority of kids who are prescribed for ADHD seem to just get a prescription and some advice about how to manage the prescription. Um, but yes I mean I think in, you know, I can, I can certainly see a rationale for, for medication if a child is just in a state where they cannot, um, and to sort of hold a child for enough time for some of these things to happen.*

Here the contrast drawn between what Olivia says '*should*' happen and what Olivia has experienced warrants Olivia's support for the combined model in principle, while '*I mean*' signals an acknowledgement of a necessary modification of this view when referring to Olivia's actual '*experience*'. Olivia's account of this experience highlights medication's dominance and the inequalities between medical and therapeutic interventions in practice ('*medication is actually the only um...sustained intervention*'). Olivia's use of a disclaimer acknowledging that there are exceptions to this rule ('*there can be some help for the parents, but, or for the child*') underlines her realistic attitude, preventing her description of '*the vast majority*' receiving '*just a prescription and some advice about how to manage the prescription*' from being taken as a purely rhetorical exaggeration. The multiple false starts that precede her next sentence ('*Um, but yes I mean I think in, you know, I can,*') indicate an attempt to repair from this forthright account of the imbalance between the medical treatment and other interventions back to the expression of belief in the fruitfulness of combining medication and psychotherapy. In describing the conditions in which she can '*see a rationale*' for using medication, Olivia employs vague, incomplete constructions ('*if a child is just in a state where they cannot, um, and to sort of hold a child for enough time for some of these things to happen*'). This imprecise language broadly categorises the use of medication as something Olivia supports in certain conditions, while reducing her accountability for the details of this. In this way Olivia simultaneously conveys her support and enthusiasm for a successful partnership between medication and psychotherapy in principle, and her lack of personal experience of this in practice. This narrative of ambivalent acceptance hints at necessary compliance with a more powerful partner.

The next extract is an example of the use of the **marriage of convenience** repertoire in response to my suggestion that there could be incompatibilities between the two treatments. My comment, which opens the extract, follows Karen's description of wanting to see children for therapy sessions at the time of the day when their medication is wearing off, so that she can get an idea of '*what the child's like*':

- S: *So in that sense it sounds like you see the, the medication as doing one job for the child in the child's world, and the therapy as doing another job, but not the medication and the therapy working together?*
- K: *Yeah, I mean I don't, I'm not saying that they can't work together, I mean they obviously are working together because it's the child isn't it? Um I suppose it's, thinking about it, you know, it depends who you've got, who's prescribing I think as to how you think about it. So you might meet, I mean that, when it works well I*

think it's good, because you can meet and you can think okay well at this dose these are the things that are happening, you know, perhaps it's time we could decrease the dose and see what happens, or let's see what happens, let's have a Ritalin holiday and let's, you know, so you can, you can evaluate things a bit more easily then.

In response to my suggestion that Karen's account implies that medication and psychotherapy function independently not collaboratively, Karen briefly voices agreement ('Yeah') but then quickly disclaims this agreement ('I mean I don't, I'm not saying that they can't work together'). As in the previous extract, 'I mean' signals an acknowledgement of the need for a modification of this view, and is used again preceding a more explicit rejection of my suggestion, in which Karen appeals to common sense ('I mean they obviously are working together because it's the child') to dismiss my suggestion. Her invitation of agreement ('isn't it?') functions to normalise this view and establish it as shared, taken-for-granted knowledge. In the following sentence Karen addresses the potential clash between her description of wanting to see the child when medication is having its least impact, and her assertion that the therapy and the medication work together. 'Um I suppose it's, thinking about it, you know' indicates an acknowledgement of the need to adapt her account in some way to manage this clash. From this point on, Karen can be seen to be working hard to establish the credibility of her view that 'working together' is feasible and conflict-free. Using conditional language, Karen portrays potential barriers to active collaboration between the two treatments as contingent on features of the prescriber ('it depends who you've got, who's prescribing'). In this way the potential for conflict is acknowledged, but is attributed to individual attitudes rather than intrinsic differences between the aims of the treatments. Karen's use of active voicing (Potter, 1996) ('okay well at this dose these are the things that are happening'; 'we could decrease the dose and see what happens'; 'let's see what happens, let's have a Ritalin holiday') works to demonstrate that these collaborative conversations are real ones, bolstering Karen's epistemic authority as someone who has taken part in them. The content of these snippets of conversations convey Karen's transparency with her prescribing colleagues regarding her wish to try reducing medication to 'see what happens'. This neutralises my suggestion that the two interventions are not 'working together', constructing both Karen and the prescribers as potentially interested in seeing the effects of a reduced dose. This positive account of creative collaboration between psychotherapist and psychiatrist seems to function to repudiate suggestions of inherent incompatibilities between the treatment models,

suggesting that any difficulties are contingent and not insurmountable. The message of partnership leaves little room for conflict.

While Karen's account conveys doubt followed by certainty about the compatibility of the two treatment models, in the following extract Deborah conveys certainty followed by doubt. In this extract Deborah is drawing a comparison between work with a private patient, in which she had very little contact with the prescribing psychiatrist, and her experience of working at a specialist educational institution (X unit) providing educational and therapeutic provision for children with emotional and behavioural difficulties:

D: *I mean, when I worked at X unit there were of course psychiatrists and but they were working in a place that was, you know, operating also as a sort of therapeutic resource. That was you know, they were people who'd signed up to work in that sort of place. So I think that would be much more like a sort of standard CAMHS as well, you know not, maybe not, I don't know, um, but you know you'd, you'd expect the psychiatrist in a standard CAMHS to be interested in talking therapies and not, you know, not averse to it, although you know, I have heard stories of psychiatrists in, in various places who, you know, firmly believe that, you know, medication is, is the right treatment and talking therapy is not.*

As in the other two extracts, Deborah's use of '*I mean*' here signals a modification of a previously expressed view that pointed to difficulties in effective joint working between the psychotherapist and the prescriber. As in Karen's account, this modification functions to emphasise the contingency of effective joint working on the attitude of the psychiatrist; in contrast to her work with her private patient, the nature of X unit meant that psychiatrists had '*signed up*' to working alongside therapists so were open to working collaboratively. Deborah goes on to speculate that this is the more common, ordinary state of affairs, for example in '*standard*' NHS child mental health services. In voicing these positive expectations of psychiatrists, Deborah performs a stake inoculation (Potter, 1996), warranting the negative portrayal of some psychiatrists that follows as fact, rather than a product of her poor opinion of psychiatrists. However by expressing uncertainty about whether this is indeed the case ('*maybe not, I don't know, um*') and reporting second-hand '*stories*' of rigid, medicalising psychiatrists '*in various places*', she raises the possibility that psychiatrists' hostility to psychotherapy is more widespread than she would like to imagine. The indirect and vague character of these reports preserves an element of deniability (Potter, 1996), distancing Deborah from this view. In this way Deborah positions herself as supportive

of and optimistic about the possibility of well-functioning joint work between psychiatrists and psychotherapists while also highlighting the potential for this to be disrupted by negative or dismissive attitudes on the part of medical colleagues.

The following extract from my interview with Laura exemplifies the construction of the impact of psychotherapy and medication as taking place in the same arena, i.e. the physical landscape of the brain:

L: *But but there's you know, there's so much that's coming out of scans and [inaudible] now that would indicate that psychotherapy can actually produce real change in different areas of the brain, including the corpus callosum, which I think is hugely important. You know if you can do that. I don't know, I don't know exactly how medication works, but it'll ch ch do something with the receptor sites of the brain. So we're not you know, we're all, we're just trying to do the same thing from different ways, different places and, but, yeah.*

The factuality of Laura's assertion that psychotherapy produces 'real change' is built up initially by vocabulary that emphasises the physicality of these changes and their capacity to be observed: The effects created by the therapeutic process have been observed in 'scans' and take place in multiple and specific locations such as 'the corpus callosum', demonstrating that they are 'real'. Laura's account of the effectiveness of psychotherapy is therefore bolstered initially by its location in the physical realm of the brain, and then by parallels between physical changes produced by psychotherapy and the brain-based processes thought to be triggered by medication. This implicitly rebuts an accusation of change in psychotherapy being uncertain or difficult to evidence compared to that produced by medication, or of psychotherapy as unconnected to neurobiological processes. The authority accorded to tangible, physiological evidence of change in this account suggests that one factor driving Laura's emphasis on the congruence between medication and psychotherapy is the perceived bolstering of the status of psychotherapy that comes with its capacity to do the same thing as medication.

Laura's remark that 'we're just trying to do the same thing from different ways, different places and, but, yeah' presents an image of collaboration and compatibility. However it is noteworthy that this remark places a broad gloss on the description, not offering further detail on exactly what 'ways' or 'places' characterise these efforts. The lack of detail in this broad categorisation of events prevents an interrogation of its factuality, and facilitates the rounding off of this conversational sequence (Potter, 1996). The

unfinished disclaimer that precedes this statement of sameness (*'So we're not you know'*) implicitly repudiates a suggestion of theoretical or methodological clashes between psychotherapy and medication, minimising conflict between the two. As in the earlier extract from Karen, this suggests that Laura is working hard at establishing the factuality of the compatibility between the two modalities.

Child psychotherapists' readiness to acquaint themselves with the medical approach to ADHD and with current research into the brain is presented in Karen's account as legitimating the recent increase in their involvement in this field. In the following extract she is talking about changes in attitudes amongst child psychotherapists since she first trained in the early 1980s:

K: *And then it became a bit more, you know, sort of people came, we've been able to come out of the woodwork, that they'd been there but they just hadn't been talked about. And then it became much more of a thing to think about. Um so I think it's become much more, you know, child psychotherapists have been much more kind of familiar with the idea of treating children with ADHD and Ritalin and, you know, thinking about the new more up to date kind of research on neuroscience and links, um sort of body mind links really, that they are linked.*

Karen positions herself and child psychotherapists in general as taking an informed, collaborative approach to understanding and treating ADHD. Her account also implicitly counteracts a potential representation of the profession as holding out-of-date or simplistic opinions that preclude members from taking an active role in this field. In describing the gradual increase in vociferousness of child psychotherapists on the subject of ADHD, Karen's description of herself and her colleagues coming '*out of the woodwork*' after having previously remained silent on the subject conveys a sense of herself and her colleagues as being unexpected and possibly uninvited in this field. This has the effect of highlighting child psychotherapists' previously marginalised status in relation to this topic. Changes in this state of affairs are portrayed as linked to child psychotherapists' willingness to familiarise themselves with diagnosis and medication (*'the idea of treating children with ADHD and Ritalin'*), and the penetration into their thinking of authoritative evidence (*'new more up to date kind of research on neuroscience'*). The authoritative connecting of psyche and soma (*'body mind links really, that they are linked'*) implicitly constructs psychotherapy and medication as suitable partners. As in the previous extract from Laura, this suitability is based on child psychotherapists' accommodation to the language and practices of the medical model, hinting at the potential power differential within this partnership.

The construction of the marriage between psychotherapy and the language of the brain as having a legitimating function is more explicit in the following extract. It begins with Laura's attempt to describe the impact on the developing brain when there has been a disturbance in the child's early relationship with their primary caregiver:

- L: *You'll have [sigh] all sorts of effects probably in terms of um trying to think, my head's gone. Well it'll affect the amygdala, it'll affect the whole HPA system, it'll um oh the oxytocin and, is it cortisol that I'm thinking of? Is it cortisol that has a diurnal? I've just gone. My head's gone [laughs].*
- S: *[laughs] [long pause] I mean what's interesting is that you seem to be I mean you're what it feels to me is that you're talking about a disturbance in a relational a relationship disturbance, but-*
- L: *Yup*
- S: *-you are also using, I think fairly unusually for some psychotherapists, you're you're using very kind of neuroscientific language um*
- L: *Mm hm*
- S: *So it it sounds to me like you're saying that um it's an emotional disturbance but that doesn't mean that it's not taking place in the brain.*
- L: *Mm hmm. Well it's a whole it's a whole mind body physiology you know it's not I don't think you can talk about one without the other. I think I think they're hugely, huuugely interrelated and yeah. I'm I'm I'm kind of I have to yeah [laughs] I just have this sort of I wonder if in the future child psychotherapists will need to take I don't know I'm not saying medicine but physiology as part of their training. Because I have a feeling that we might. Or that it might help us in our in our profession if we did.*

The function of the first part of Laura's account seems to be to demonstrate the compatibility of environmental and biological explanations for ADHD symptoms. The sigh that precedes her description of hormonal activity in the brain communicates both a sense of preparing for an important task and of resignation to the need to do this. Laura's use of the technical vocabulary of the brain, and reeling off of a list of areas that would be affected by maternal deprivation in early infancy, denotes a sense of ease with making links between environmental and neurobiological processes. The expression, '*I've just gone. My head's gone*', implies that Laura's difficulties articulating these links are related to her struggle to recall this knowledge, rather than any incompatibility in the subject matter.

My summary of what I thought Laura was trying to convey with this description was produced partly by a feeling of anxiety in response to the breakdown in Laura's narrative, which compelled me to try to keep the momentum going. My version acknowledges her use of the language of the brain, characterising this as unusual

within her profession, and interprets her words as acting to repudiate simplistic nature nurture division. This version is ratified by Laura's sounds of assent ('Yup', 'Mm hm'), the tone of which conveyed the taken-for-granted, irrefutable nature of this formulation of the interdependence of mind and body. The remainder of Laura's account seems to address potential criticism that may have been perceived in my drawing attention to her use of '*neuroscientific*' language, justifying the crucial importance for child psychotherapists (me included) of developing literacy in this area. After establishing the factuality of her understanding of the inextricability of psyche and soma using hyperbole (*'I think they're hugely, huuugely interrelated'*), the hesitations and false starts preceding Laura's next sentence are suggestive of dilemma or conflict about what she is about to say. In identifying '*physiology*' as the area that '*in future*' child psychotherapists might '*need*' or which '*might help us in our profession*', Laura highlights her understanding of knowledge of the physical processes of the brain and body as having a powerful, legitimating function. Her use of a disclaimer (*'I'm not saying medicine'*) pre-empts the potential accusation that this would entail a wholesale adoption of the framework of doctors or psychiatrists. Rather, child psychotherapists' increasing familiarity with physiology is constructed as potentially enriching the profession of child psychotherapy through enhancement of its compatibility with a neuro-physiological perspective.

A marriage of convenience is a repertoire of explicit congruity and implicit conflict between psychotherapeutic and medical interventions for ADHD. It functions to minimise differences between drug and therapy interventions, and to convey participants' belief in the compatibility of the two treatment modalities. At the same time however, this repertoire entails expressions of ambivalence and doubt. Effective joint working is constructed as an ideal principle that is rarely possible in practice. Psychotherapists' enthusiasm for incorporating a neuro-physiological perspective into their work is portrayed as appealing in part due to its potential for legitimating the profession of child psychotherapy, foregrounding possible political concerns driving narratives of compatibility between psychotherapy and medication. Thus, despite the prevalence in the interview material of expressions of support for combining the two treatments, this examination of the language and rhetorical devices employed by participants suggests that this support is better understood as ambivalent acceptance or superficial compliance linked to professional power differentials.

Separate lives

In this repertoire, the impact of medication on patients or on the psychotherapeutic process is constructed as an elusive, complex area about which reliable knowledge is difficult to access. Like **A marriage of convenience**, **Separate lives** conveys a double message. It entails explicit statements of interest in and engagement with the medical intervention, alongside narratives of difficulties or failures in linking up with or thinking about the psychopharmacological side of the child's treatment. The impossibility of reliably disentangling cause and effect and lack of expertise in the medical arena are cited as factors preventing participants from knowing, thinking, talking or making definite pronouncements about medication. In this way, critical views about diagnosis of or medication for ADHD are voiced while also being rejected as outside the remit of the immediate conversation or task. In some accounts the medical treatment is presented as an unavoidable but essentially irrelevant aspect of the work with the child, which does not enter the psychotherapist's frame of reference when formulating an understanding of the patient. Thus participants position themselves as agnostic about or indifferent to the impact of the medical intervention. They present themselves as taking an open-minded but circumspect attitude to this area, thereby disclaiming possible attributions of automatic or unconsidered rejection of the medical intervention. By invoking uncertainty and the confines of their roles as barriers to engaging with the medical treatment, participants stop short of actively challenging the practice of medicating children or combining medication with psychotherapy. Nevertheless, **Separate lives** is a repertoire of avoidance and implicit resistance to the combined model.

Accessing reliable knowledge on the impact of medication is presented as problematic in the following extract from my interview with Jenny. This excerpt follows Jenny's reflection that she thinks sometimes medication can '*boost things sufficiently to [help children] access...life a bit more*'.

- S: *So have you had that experience of that happening at all, kind of medication helping a child access either their therapy or some other things in their life or?*
- J: *I don't know, I, I, it's so hard to know, as you say, you know, it's so hard to disentangle it. Um, but, but, yes, I mean two young people that I can think of in my private practice were both on medication; one for ADHD and then he, then he came off it, now was, did he come off it, put himself off it, did he come off it*

- because he was feeling better? And then towards the end of our work actually went back on it*
- S: *Right. Is it, is this, is this the teenager?*
- J: *Yeah.*
- S: *Mm-hmm.*
- J: *Sorry your question was did I feel that it helped access the therapy?*
- S: *Yes I suppose you were saying, I think you said both that you, it could either you thought, so that, you know, could either help access therapy or kind of life. But, you know, whether you've had that experience of that, of medication doing that.*
- J: *Oh I, I, I think so I mean some of, all the very serious kids I've worked with I think at some point have had some form of medication. Um. I think as they feel better they try to come off it, um, with varying degrees of success, maybe then when they're beginning to feel more capable, and more resilient um, they then want to be more independent of it but then feel the therapy even more profoundly, more disturbingly, I don't know, and then they're back on it. You know but then not consciously. Uh, as I say, I'm, I'm I'm ashamed to say that I've never really properly tracked it to know when exactly it's coming in with the therapy and out with the therapy and how, how the two are in, you know, interfaced.*

Jenny's response to my question about her experience of the impact of medication on children (*'I don't know, I, I,'*) conveys hesitation and uncertainty, suggestive of conflict. This conflict seems to relate to the potential dissonance between Jenny's portrayal of the helpfulness of medication to children in accessing *'life a bit more'*, and her difficulty identifying specific examples of this. In the next sentence (*'it's so hard to know, as you say, you know, it's so hard to disentangle it'*), her use of *'you know'* and her invoking of a word I had used earlier (*'disentangle'*) constructs her uncertainty as something ordinary and understandable, about which we are in agreement. Jenny's questions to herself (*'did he come off it?'; 'did he come off it because he was feeling better?'*) further underline her difficulty accessing definite knowledge about this subject, adding the fallibility of memory as another factor hindering her capacity to answer this question.

Indeed in this exchange we become somewhat entangled ourselves, leading to Jenny asking me to re-state the question. In attempting a second answer Jenny seems to be working to simultaneously display authority and uncertainty. Her *'oh-receipt'* to my question marks a change of state and indicates Jenny's epistemic priority over me (Potter and Hepburn, 2008). This is further bolstered by her use of hyperbole (*'all the very serious kids I've worked with'*), indicating her knowledge and authority on the subject. At the same time Jenny continues to frame this tentatively, hesitating and using broad, vague descriptive constructions (*'I think at some point have had some form of medication'*). The impact of medication is then constructed not as something helpfully facilitating Jenny's patients' engagement with therapy or other aspects of life, but as

something triggering a rather hopeless sounding cycle of stopping and starting medication. The tentative, uncertain elements in Jenny's account can be understood as part of a psychoanalytic discourse, which resists the rigid adherence to certain or definite knowledge. Here this psychoanalytic stance functions to highlight the speaker's reluctance and inability to make causal inferences in this complex area, and to shift the focus from the direct, causal impact of medication onto the potential psychological meaning of taking medication to the patient (*'maybe then when they're beginning to feel more capable, and more resilient um, they then want to be more independent of it'*). Jenny's confession of shame at not having rigorously *'tracked'* the interaction of the two treatments works to acknowledge the ongoing difficulty in answering the question and to highlight her good intentions in regards to engaging with the medical treatment. Her doubt, uncertainty and hesitancy about the impact of medication on her patients are therefore constructed as products of the complexity of the subject, rather than disregard of or lack of evidence of any effects of the drug treatment. Thus despite Jenny's explicit emphasis on the potential helpfulness of medication to children in accessing life, this account foregrounds her struggles with reliably knowing about or engaging with the medical side of the child's treatment.

The presentation of knowledge about the impact of medication as hindered by the difficulty of disentangling a multiplicity of factors affecting the child is further exemplified in the following extract. Deborah is talking about one of her patients who she described as feeling *'odd and weird'* and has just commented that she thinks the medication made no difference to this *'one way or the other'*:

- S: *And you think it made him feel neither more nor less odd and weird?*
D: *It seemed like a bit of a relief. But it did come in the context of was he going to be thrown out of school so you know, I'm not sure whether the relief was to do with, you know, that they'd got away with it or they you know, they'd found a way of categorising things that meant he didn't get thrown out of school.*

Here Deborah responds to my clarification about the non-impact of medication with an implicit although somewhat uncertain contradiction (*'It seemed like a bit of a relief'*). This seems to act as a concession to the possibility that medication may have had some impact on her patient's self-image. However she quickly begins interrogating the provenance of this sense of relief, identifying other potential sources for it, i.e. the reversal of the expectation that he would be excluded from school (*'that they'd got*

away with it) or the sense that the prescribing of medication had enabled the school to take a less punitive perspective on this child (*'they'd found a way of categorising things that meant he didn't get thrown out of school'*). This account of Deborah's uncertainty about whether her patient's relief was a direct result of the medication or not constructs knowledge about the impact of medication as problematic in two ways. First, it underlines the multiplicity of factors that could produce the same effect, emphasising the complexity of attributing specific effects to the medication. Second, it privileges the impact of the meaning of medication on children and their families, and the potential for this to operate via systemic responses to the meaning of the act of medicating, rather than directly on the individual. This is particularly clear in Deborah's move into the third person plural when she says, *'they'd got away with it'*, implying that the relief was not just that of her patient, but of his parents as well. The sense of trickery or artifice implicit in getting away with something and in finding *'a way of categorising things'* to produce a particular effect suggests an element of scepticism about the use of diagnosis or medication for this boy. In this context Deborah's framing of these views with an expression of uncertainty (*'I'm not sure whether'*) seems to function to warrant this scepticism as considered, emanating in part from an inherent difficulty accessing reliable knowledge of cause and effect, rather than from a hasty or injudicious dismissal of the direct impact of medication on her patient. Again, scepticism about and implicit resistance to the practice of medicating can be detected in Deborah's presentation of uncertainty about the impact of the drug treatment.

It was common for interviewees to prefix comments about medication with disclaimers conveying their lack of expertise in or uncertainty about the subject, such as, *'of course the use of medicine is not my area'* (Rita) or *'I don't know if this is right'* (Olivia). Disclaimers often accompanied the expression of critical attitudes, as in the following extract from my interview with Laura:

- L: *I don't have a problem with it at all. I think we're all trying, we're all trying to, you know, achieve the same [laughs] in in whatever formats we can. Um I, I mean, I, uh, my only, my only reservation is I don't know that we really know about the long-term effects of medication really. That that's my only reservation, but I feel like that's not my remit [laughs].*

In this extract Laura performs a stake inoculation (*'I don't have a problem with it at all'*), characterising herself as someone with a favourable attitude towards this practice. Her hesitant approach to voicing her concern about the unknown impact of the use of

psychopharmacological drugs (*'Um I, I mean, I, uh, my only, my only reservation is I don't know that we really know about the long-term effects of medication really'*) and her emphasis on this being just a single concern (*'That that's my only reservation'*) convey her reluctance to express this critical view. These rhetorical moves warrant the factuality and trustworthiness of Laura's '*reservation*' about the use of medication as emanating from a position of acceptance and support rather than prejudice or mistrust. By reiterating that this is an isolated concern, and disclaiming her right or permission to give her view on this subject (*'I feel like that's not my remit'*) Laura continues to distance herself from both the critical view and from the subject itself, positioning herself as reluctant to be drawn into this arena. In this way Laura simultaneously espouses and disclaims a critical attitude towards the practice of medicating children for ADHD. In her account, the child psychotherapist is portrayed as avoiding too deep an exploration of the characteristics of her medical partner, lest it produces unpalatable or irresolvable conflict. This agnostic position therefore entails both superficial compliance with and implicit resistance to the practice of medicating children for ADHD.

As well as portraying the impact of medication as outside the scope of their knowledge or commentary, it was common for interviewees to present an attitude of indifference to the use of medication alongside their treatment. Jenny described how she had been '*against*' the use of medication, but that this had changed. When I asked in what way she explained:

J: *I, I really just ignore it now and press on and feel what's going to make most meaningful lasting change is the rela- you know, is, is, is, quality of relationship and then quality of medication. So I don't mind anymore if they've medicated. I suppose I've never had the problem with me, that I've never kind of looked at has it affected our relationship. But even if it has I'll just press on, you know, we're trying to get meaning out of our relationship.*

Jenny's change in this account is from a position of opposition to a position of equanimity. The image of pressing on is suggestive of continuing despite irksome hindrances. In positioning the therapeutic relationship as the aspect of treatment that is '*going to make most meaningful lasting change*' Jenny implicitly elevates the psychotherapeutic process above a potentially troublesome or ineffective medical intervention. Indeed in breaking off from saying '*relationship*' the first time, then repairing to list '*Quality of relationship*' then '*quality of medication*' as the two factors

most capable of producing change in the patient, Jenny seems to be modifying this statement in order to defend against potential accusations of complete dismissal of the medical intervention. After restating her lack of hostility to her patients being treated with medication Jenny reflects that in fact whether medication has an impact on the therapeutic relationship or not, it is no more significant than any other factor to be understood in the psychoanalytic pursuit of meaning. Thus while indicating Jenny's lack of active opposition to the use of medication, this account works to convey indifference to the use of medication or its impact. Later in the interview Jenny explained that she rarely thinks about the impact of a child's actual experience of the medical intervention in sessions, even when they engage in symbolic play about medication. For example in describing her patient's pretend play about taking medication, Jenny reflected, *'I haven't thought of it directly and concretely as the medication he gets at the home, but more, more what he needs from an attentive maternal figure, making his heart feel better...I've never thought of it concretely as what they're getting in the, in the home until now'*. When I asked about the specific impact of medication on the therapeutic process, it was frequently constructed as unimportant, in that it is treated as no more or less significant than other aspects of the child or therapeutic process. This is exemplified by the following extract from my interview with Deborah:

- S: *Do you notice when working with those children, any kind of differences compared to working with other types of children in kind of your actual experience of working with them, when they're on the medication? Um, you know, as a psychotherapist I suppose.*
- D: *Hmm. I just don't feel I can answer that in the sense that I think one's experience of working with every child is different. So that, you know, when you're working with Johnny, Johnny is like Johnny is. And you know, when you're working with Dave, Dave is like Dave is and so in that sense, you know, I sort of feel like it's sort of you know, comparing apples and pears. Is it different working with a child who's got an ADHD diagnosis or the child who hasn't, every child who comes is sort of different so I don't, I don't think so. Um, I mean certainly, you know, X unit life, children who sort of gave you the run around, you know, there would be, you know, there's, there's a real sort of, there's a real run around and there were children, you know, children who hit and bit and spat um, and I think you know, I think one's whole approach is you know, is, is probably different than with a child who sort of acts out physically, but I'm not sure where the medication comes in to that.*

The repetition and hesitation in my question, as well as my use of the term '*actual experience*' stems from my growing awareness during the interview that Deborah's

account somewhat nullified the role of medication, in that although she expressed theoretical support for the use of medication to help children manage better, specific examples of this were absent from her accounts of her clinical experiences. In response, Deborah highlights her sense of this question going outside her remit (*'I just don't feel I can answer that'*). She goes on to construct both medication and the diagnosis of ADHD having no specific impact on the therapeutic task or process. The use of the *'apples and pears'* idiom conveys the irrelevance to Deborah's understanding of her patients of a diagnostic framework that aims to group together presenting symptoms. Indeed in portraying the considerably challenging behaviour of the children she came across at X unit, the absence of the vocabulary of hyperactivity, inattentiveness or hyperactivity seems significant. The ordinary language employed by Deborah to describe their challenging behaviour (*'hit and bit and spat'*) and her framing of this as acting out *'physically'* construct these as behaviours with unspecified origins, rather than symptoms linked to ADHD. This implicitly repudiates the notion that these behaviours can be helpfully explained or understood with an ADHD diagnosis. Her implicit challenge to the psychopharmacological intervention is encapsulated in her equivocating statement of uncertainty about the role of medication (*'I'm not sure where the medication comes in to that'*). Thus, Deborah's profession of an inability to answer the question of whether there are observable differences in children taking medication seems to be an expression of reluctance to engage with the diagnostic framework underpinning the medical treatment model. Both Deborah's and Jenny's accounts construct child psychotherapists' understanding of children as operating in a completely separate and possibly conflicting arena to the understanding underpinning the medical model of ADHD.

A more explicit rejection of medication's significance for the therapeutic process can be found in the following extract from my interview with Laura:

- S: Do you um, when you're when you're going to see a child, or you're seeing a child and you know that alongside your work, um there'll be a a drug therapy, do you think about the work any differently?
- L: So do I think about the work?
- S: Any differently, to how you would think about a child that wasn't having a, a concurrent drug therapy for example?
- L: [Long pause] I don't, I didn't understand that.
- S: Um, mm ok. If you're see a, if you're seeing a child that is being medicated simultaneously to having therapy with you, um do you think about them, you

know does that change your thinking at all in terms of thinking about the work, thinking about how you might work with them?

- L: *Not really, no, [laughs] no I don't think so. I mean I'm aware, the only thing that, might come up for me that really impacts on me is sort of sort of go would I will I arrange a medication review with the psychiatrists [laughs] But but really, I don't think it, it impacts on me. I have the child in the room [laughing] and I have the child who's there [laughs].*

It is notable here that Laura asks me to clarify my question twice before she can find a way to answer it. Her request for clarification after my first question then her pause and statement of non-comprehension following this clarification convey powerfully the sense of this question reaching outside the remit of her thinking and of her work, communicating like Deborah, her sense of being unable or perhaps unwilling to answer it. It may be that my use of the term '*drug therapy*' was one factor contributing to Laura's confusion, as this seems somewhat resolved after I change to using the term '*medicated*'. This in itself suggests something inherently confusing in framing the psychotherapeutic and medical interventions under the same category of having therapeutic action on children. Laura's reply actively downplays any overlap between the two treatment modalities and foregrounds the absence of consideration of medication in her clinical thinking. Her comment on considering whether a medication review is needed seems to function to highlight her acceptance of the multimodal nature of her patients' treatment, defending herself against the potential accusation that her focus on '*the child in the room*' indicates a detachment from external realities or from the multidisciplinary setting. This seems particularly important in the light of the thrust of her reply, which strongly implies opposition to categorising children by the presence of medication, or indeed categorising children whatsoever, therefore implicitly repudiating a diagnostic framework, in favour of one which focuses on '*the child who's there*'. Thus Laura conveys tolerance of the administrative necessities of the medical intervention, but complete indifference to its clinical impact or meaning.

Separate lives is a repertoire of avoidance of and implicit resistance to the practice of medicating children alongside psychotherapy. By professing their acknowledgement of or enthusiasm for the need to engage with the medical side of the treatment, participants convey an open-minded, supportive attitude to medication. At the same time they characterise knowledge about the drug treatment and its impact as elusive, unreliable, irrelevant to or incompatible with the psychotherapeutic process. Thus

without openly criticising the medical model, the interviewees' accounts challenge its effectiveness or importance in the understanding and helping of their child patients.

For the sake of the children

This repertoire entails two related positions adopted by participants in talking about psychotherapy with medicated children. In the first, the practice of medicating children diagnosed with ADHD is constructed as a desperate measure necessitated by the uncomfortable reality of limited resources and the severity of the impact of children's difficulties. Medication is simultaneously portrayed as an unpleasant last resort and a potentially harmful collusion with a pathologising attitude towards the child. Participants invoke pragmatic reasons for accepting the use of medication, in particular to make things easier for poorly trained carers or families on the verge of breakdown. These factors implicitly justify this practice as being in the interests of the child. In this way the use of medication is constructed as less than ideal or morally questionable but also hard to resist in the context of the challenges and demands of work with complex children and families. Interviewees position themselves as subject to force majeure, limited in their capacity to fully oppose the use of medication by its powerful authority and systemic meaning. In the other position within this repertoire, participants construct symptoms of ADHD as communications of distress that are meaningful and can be helpfully understood. Psychotherapy is portrayed as eliciting and addressing these painful feelings in the child, which are initially communicated in the form of symptoms of hyperactivity, inattention and impulsivity. By presenting these changes as significant and progressive, particularly in the context of considerable obstacles, participants present psychotherapy as a powerful though underrated alternative and rival to drug treatment. As such they position themselves as implicitly challenging the practice treating ADHD with medication aimed at symptom eradication, suggesting that this practice has the potential to collude with a de-contextualising, pathologising view of the child which risks silencing important communications about their experiences and needs. This challenge is largely implicit but deeply embedded in participants' clinical formulations of their patients and their interventions.

In the following extract, in which Laura is responding to one of my first questions about her understanding of the diagnosis of ADHD, the realities of the care system are understood as driving diagnosis. In presenting these realities as uncomfortable but also

understandable and unavoidable, Laura both challenges the practice of diagnosing ADHD and displays her acceptance of the pragmatic realities that underpin this practice:

- L: *Ok fine. Um...Ok, I'm going to clarify that this is the population that I deal with which is Looked After.*
S: *Right.*
L: *Um, how it gets diagnosed is quite often because the carers want it to be [laughing] diagnosed.*
S: *Right.*
L: *I think. Er um, sometimes they get a...extra payment for...difficulty of child that they're looking after.*
S: *Right.*
L: *Um...some of them find it easier to tick a box that a child's got a diagnosis and a medication then they can ah look think about it differently so that actually it can be helpful to have the diagnosis just in terms of...the way a carer can, can conceptualise and and it can just give a space which can be helpful.*

Laura's initial hesitation conveys her treatment of the question of diagnosis as a complex subject that requires thought and preparation. This is followed by a disclaimer regarding the nature of the group of children she will discuss, which functions to warrant this view as intrinsically bound up with the particulars of children and carers in the care system. The sceptical laughter that accompanies Laura's description of the process of diagnosis as driven by the wishes of the carers characterises this as an inadequate or absurd reason to make this diagnosis. Her hesitant identification of monetary factors ('extra payment') compelling the wish for diagnosis positions carers as placing financial needs before the needs of the child. However the statement that follows turns this on its head, portraying diagnosis and medication as playing a crucial role in enabling carers to think about the child. Thus these practices are transformed from being excuses for remuneration into being necessities for holding the child's needs in mind. In constructing diagnosis and medication as unrelated to aspects of the child but playing a role in fulfilling both financial and psychological needs of the carer, Laura presents herself as taking a pragmatic stance in accommodating a suboptimal but unavoidable reality.

The construction of the use of medication as an uncomfortable yet inevitable reality is further exemplified in the following extract from my interview with Deborah:

- D: *I mean I remember X unit, there was one little boy who, whose mother and stepfather, father and stepmother, I don't remember, um, but I mean I remember it was a sort of, not an intact family, um, found him incredibly difficult and I*

remember the psychiatrist saying she was going to medicate him to make their lives easier. Not because she particularly thought that the child needed it and you know, in one way that was sort of quite shocking. In another way what, one could see that it was an attempt to enable these parents to keep this child at home. When they were seriously considering that he shouldn't stay at home and in fact ultimately he didn't ultimately, he did go off to a residential school. But you know, you sort of, it, it felt uncomfortable but I could sort of see it.

This extract follows reflections by Deborah on her tendency to gravitate towards identifying parental management factors that might be propelling the child's hyperactive or inattentive symptoms, and her scepticism about the concept of ADHD as a diagnosable disorder. Her use of '*I mean*' here functions to indicate a modification of these views, expressing pragmatic acceptance of the use of medication even when there is consensus about the spuriousness of the diagnosis. The decision by the psychiatrist to prescribe medication in order to make a child more manageable for a struggling reconstituted family is presented as '*sort of quite shocking*'. This use of '*sort of*', which is echoed twice more when Deborah expresses both her discomfort with and acceptance of this approach, foregrounds the murky, uncomfortable nature of Deborah's articulation of her views on this subject. At the same time her formulation of the psychiatrist's decision as an '*attempt to enable these parents to keep this child at home*' conveys something effortful, although potentially fallible, motivated by the interests of the family. This works to highlight Deborah's empathy with her colleague's predicament and with her ultimate aims, and her acceptance of the uncomfortable reality of the situation. Deborah's addition of a postscript of this boy's eventual placement in a residential school alerts the listener to the fact that both Deborah's and her colleagues' worst fears were confirmed. Deborah's account establishes the impossibility of the situation, therefore justifying the acceptance of desperate measures, while also bringing into question the efficacy of medicating the child. This conflict is managed by Deborah with a restatement of her dilemma, preceded by '*But you know*' which functions to elicit agreement about the dilemmatic and complex nature of this problem. Deborah and her colleague are positioned as acting under duress, hemmed in by the intensity of suffering experienced by child and family, and by the proclaimed (but contested) power of the medication to alleviate this.

In the following extract, the realities of the limitations of training and the working environment are invoked by Jenny to explain, justify and question an uncomfortable acceptance of the use of medication:

J: *But there's so much going on with the team maybe I've become a bit institutionalised myself believing that actually it helps them just relax a little bit so that they can be looked after. But that's a benefit. But it is a bit of a short cut, because, you know, the carers on the whole are very young and require a lot of training and you feel this. And you do wonder, and I have wondered, and which is why they, you know, have my, presumably why they come to case discussion and child focus meetings, to kind of really develop their thinking and not quickly resort to quick, quick efforts, you know, uh thoughtlessly punitive or, or, or kind of, you know, or issuing consequences that aren't properly thought out or, you know. You do wonder if they were better trained and more informed would this obviate the need for such medication. And sometimes does feel like it's, um, a way of helping the carers care for kids more than it's often you know, for their benefit.*

By positioning herself as possibly 'institutionalised' in her belief that medication can benefit her patients, Jenny foregrounds the power of the institution in which she works to influence her judgments, while also disclaiming an unthinking acceptance of these institutional norms. Her description of the potential facility of medication to assist in helping children 'relax' or be 'looked after' ascribes a parental function to medication which constructs its use as benign and compassionate and works to justify Jenny's compliance with a potentially fictitious view of medication as beneficial. The formulation of the use of medication as a 'short cut' introduces the idea that medication's appeal lies in its promise of a quick fix, which is understandably appealing to Jenny's inexperienced young colleagues and to Jenny herself. Jenny and her colleagues are constructed as well-intentioned in their attempts to avoid short cuts, Jenny by pondering on these issues and providing fora to discuss children, and her colleagues by attending these discussions. Jenny's use of the second person ('*and you feel this*'; '*And you do wonder*') works to position her as both implicated in and attempting to stand outside of these dynamics, emphasising the dilemmatic nature of her situation. Her invocation of the potential for better training to reduce the need for the use of medication highlights the role of wider socio-cultural or economic forces in constructing this uncomfortable reality, emphasising its intractability while also communicating Jenny's wish for it to be otherwise. Her final sentence echoes the construction of the use of medication found in the previous two extracts, as a potentially morally questionable method of reducing the burden on overstretched or under-resourced carers ('*And sometimes does feel like it's, um, a way of helping the carers care for kids more than it's often you know, for their benefit*'). While acknowledging the powerful forces driving this practice, Jenny's distinction between the helpfulness of medication to carers and the 'benefit' it affords their children brings

into question the idea that helping those looking after children by prescribing medication is really in the best interest of their charges.

The following extract is an example of how participants construct the psychotherapeutic process as benefitting children in a very different way to medication. Karen describes physical and emotional transformations that she observed in one of her patients while he underwent psychotherapy:

- K: *Um and he changed from being a very, a very physically tough robust um what's the word, highly mobile agile child, um sort of almost like a little ball of muscle really, to becoming quite a depressed.*
- S: *Right.*
- K: *Sort of droopy kid with runny noses and colds and.*
- S: *Right.*
- K: *That sort of happened, you know, during the course of treatment.*
- S: *That's quite a big change.*
- K: *It was a huge change, and then he came out of that but for a period he was very very low, very miserable yeah, a very sad little boy really.*
- S: *Okay.*
- K: *So that yeah, and that's quite important I think in terms of the treatment of maybe what needed to happen.*

This description presents an inversion of ordinary expectations of what might constitute progress. Karen's initial description of her patient is not an explicitly negative one. A 'physically tough robust' child who is 'highly mobile' or 'agile' could evoke an image of strength and physical prowess associated with a particularly healthy child. However, the addition of the image of 'a little ball of muscle' orients the listener to there being something excessive in this child's toughness, with a tight, defensive quality. Similarly, Karen's description of the change from this vigorous, muscular presentation to a sad, lethargic, sickly one does not overtly communicate a positive trajectory in her patient's well-being. However she goes on to describe these changes as 'important' and 'what needed to happen', again inverting the negative perception of misery and depression in a child, and characterising this as progressive and beneficial. Thus the child's tough physicality is constructed as a defensive, maladaptive way of managing painful emotions, and his excessive sadness is constructed as a necessary feature of his recovery. Karen's use of hyperbole when she modifies my description of the change from 'quite...big' to 'huge', works to confirm the significance of this change. The establishment of the temporary nature of this excessive sadness ('and then he came out of that') functions to warrant the validity and clinical salience of Karen's understanding of her patient's progress. This account establishes the capacity of the

psychotherapy treatment to produce unexpected effects in children diagnosed with ADHD, with the injection of emotional meaning into outward physicality and behaviour playing a central role. The emergence of an openly distressed little boy out of Karen's robust, agile, tightly wound patient is at odds with the image of the more manageable child portrayed as potentially produced by medication. In this way the role of the psychotherapeutic process in eliciting and attempting to understand feelings previously experienced as unbearable presents an implicit challenge to the medical model of eradicating symptoms and improving behaviour.

The contextualisation of children's behaviour and difficulties within their current and previous experiences was central to all the participants' narratives about their understanding of children diagnosed with ADHD. Traumatic or deficient experiences of early caregiving and ongoing environmental stressors were understood as central in the development and understanding of their patients' challenging or hyperactive behaviours. In the following extract Jenny is talking about a Looked After child who she treated in her work at a residential children's home. This extract follows Jenny's comments on her patient's *'very traumatised background'*, which included witnessing domestic violence and maternal drug use while pregnant:

- J: *Um, however, um, I have seen quite considerable development um, in the last six months, and this seems to be supported by what the house, residential home and the school are saying.*
- S: *Right.*
- J: *It's probably more evident in the house than in the school.*
- S: *Okay.*
- J: *But even the school have noticed that she's kind of, you know, they've described how she's actually looked more, uh, they haven't said thoughtful but they've said you know, she, she's sometimes come back looking sad, which is not something that they often seen her be anything other than hyperactive. Um, they've also commented that she's started talking about family members. And, and kind of just begun to differentiate between her foster carer and her mother, because she was removed quite early when she was quite young about aged three.*

Jenny's use of *'however'* preceding her description of the *'quite considerable'* changes she has witnessed constructs these changes as unexpected in the context of her patient's early caregiver experiences. This conveys both the complexity of her patient's difficulties and the capacity for psychotherapy to address this level of complexity. Developments in this child's emotional repertoire (*'she's sometimes come back looking sad'*) are presented as noticeable and meaningful not only in the limited confines of psychotherapy, but also in the broader contexts of the child's academic, domestic and

family life. Jenny invokes witness consensus (Potter, 1996) to corroborate this; the consensus of school staff is framed as particularly reliable and significant since the changes are identified by Jenny as being more likely to be noticed outside the school setting (*'in the house'*). By commenting that school staff have not described her patient as *'thoughtful'* but as *'sad'*, Jenny implicitly constructs a link between her patients' increased expression of negative emotions and improvements in her capacity for reflecting. Similarly, in positioning her patient's sad expressions as a new development following behaviour that was exclusively hyperactive, this hyperactivity is implicitly constructed as linked to inexpressible painful emotions and the emergence of negative emotion is established as meaningful and progressive. Jenny's additions of others' observations of developments in her patient's engagement with familial relationships functions to corroborate this progress as *'considerable'*, implying that its effects extend into the relational context which is understood as an important factor contributing to this child's difficulties. As in the previous extract from Karen, Jenny's attribution of emotional and biographical significance to ADHD symptoms, and treatment of these symptoms as meaningful, creates implicit conflict with the use of medication to eradicate symptoms.

The capacity of the psychotherapist to translate behaviour into meaningful communication was a common theme throughout the interviews. The development of an alternative perspective on children previously thought of as damaged and damaging was central to their narratives of therapeutic success. This can be seen in the next two extracts, in which Olivia is describing a Looked After boy that she treated in psychotherapy:

- O: *[I]t was like all his behaviour was, um, in a way there to make sure that he was never left on his own, because-*
S: *Right.*
O: *And that there was always a parental mind.*
S: *Right.*
O: *It was like he was constantly saying you cannot leave me on my own.*
S: *Right.*
O: *Because if you do, you know, I will or the, this building will fall down or I will do something so awful that um, you'll never do it again.*

Later in the interview Olivia said of the same child:

- O: *Um he ended up with some quite good exam results, reasonable, I mean they weren't brilliant, but they were much better than had everybody hoped. And his, uh, situation with his foster family got better. You know, he was, there was a baby*

around and, you know, there'd been a lot of worries about him being alone with the baby. Um, but over that last year he became very much a very important figure for the baby and one who was very involved in her care actually. They've even on his own with her. Mm. So there were quite, it felt like there were quite a lot of improvements which were kind of sustained over that last year.

The first extract exemplifies the construction of Olivia's patient's behaviour as communications with emotional and relational significance. She frames her account tentatively, highlighting its interpretative nature (*'it was like all his behaviour was, um, in a way there to make sure that he was never left on his own'*). However her active voicing of her interpretation of this behaviour (*you cannot leave me on my own...Because if you do, you know, I will or the, this building will fall down or I will do something so awful that um, you'll never do it again'*) brings the child dramatically into the narrative and underscores the intensity of the emotional demands and difficulties that Olivia interprets as linked to his caregiver relationships. Olivia's articulation of these demands presents the psychotherapist as capable of understanding this behaviour despite its codified presentation. In the second extract, Olivia's patient's *'quite good'*, *'reasonable'* exam results are described as *'much better then everybody had hoped'*, foregrounding her patient's progress as surpassing expectations. Olivia's breaking off from her account of his involvement with caring for the baby to add *'even on his own with her'* again emphasises the contrast between this and her patient's original state, in which leaving this child alone with a baby was considered unsafe. This conveys the development of a new perspective on a child previously felt by those around him to be extremely difficult and even dangerous. This construction of the therapeutic process as translating deviant behaviour to reveal its emotional significance and link it to the child's experiences again implicitly resists the individualising, de-contextualising elements of the practice of medicating children diagnosed with ADHD.

As this analysis so far has shown, the challenge to the practice of using medication to eliminate rather than understand and contextualise hyperactive, inattentive and impulsive behaviour is mostly an implicit, unspoken one. The following, final extract, in which Rita refers to *'madness'* in the child's family life, which she suggests can present a barrier to the child's capacity to engage with psychotherapy, is a rare example in the interview material of an explicit challenge to the use of medication to intervene with children diagnosed with ADHD:

R: *There is some madness that it's so toxic that these children cannot, you know, digest and make sense of, and they become sort of so active in a mindless way. But once you start to differentiate the madness from their own, you know, healthy side, they do settle, but sometimes it's possible, sometimes impossible. I mean it's really, is a question how the environment will support the child throughout the therapy, because therapy is quite difficult for these children. It almost for them feels initially like a torture, because they, it's what exactly they don't want to do, to be with an adult in a room, because in their mind these adults are mad, and they do have mad adults in their fam- environments. It's not just their fantasy; it's often the reality.*

As in the previous extracts, here Rita constructs the excessive activity of children diagnosed with ADHD as a maladaptive attempt to process painful or 'toxic' feelings or experiences. 'Madness' in this account, with its connotations of dangerous, adult insanity, is located firmly outside the child and in the adults or environment around her. Rita emphasises that if helped to extricate themselves from defensive mindlessness, children 'do settle', but this vision of therapeutic success is quickly problematised as 'sometimes impossible'. Following this Rita's use of the modifier, 'I mean', and her introduction of the 'question' of the supportiveness of those caring for the child highlight how far the possibility or impossibility of therapeutic success is influenced by factors outside the therapist's immediate sphere of influence, such as the child's experiences of caregiving. This account firmly repudiates the notion of the child's symptomatic behaviour as understandable outside the context of their experiences. The child and the therapist are constructed as struggling together to locate the child's 'healthy side' against the odds of the collusive locating of 'madness' in the child rather than in their environment. Later in the interview Rita links this collusive de-contextualising of the child's difficulties to the practice of medicating, commenting, 'But if the environment is so chaotic, like if madness is going on, I think that medicating a child is contributing to the madness really.'

For the sake of the children speaks to the dual pressures inherent in participants' accounts of intervening with children diagnosed with ADHD. On the one hand they portray their temptation to accede to the demands of a stretched, distressed system to condone a quick, painless, authoritative solution to desperate families and professionals responsible for caring for demanding children. On the other hand they construct a vivid picture of the child and the experiences behind the diagnosis and the behaviour, and implicitly resist the location of madness or deficiency inside the individual child. In displaying their sense of feeling compelled to accept the use of

medication for their patients, alongside their understanding of their patients' problematic behaviour as significant communications that can eventually be understood and transformed, participants communicate both acceptance of and resistance to the practices and assumptions of the medical model of ADHD.

Summary

The interpretative repertoires identified and described in this section can be understood as existing on a spectrum of acceptance of and resistance to the practice of medicating children diagnosed with ADHD. At one end, **A marriage of convenience** involves acceptance of the use of medication as theoretically compatible with and even supportive of psychotherapeutic input. However this acceptance is suffused with ambivalence and doubt. Fruitful collaboration between the treatment modalities is portrayed as an unobtainable ideal, and overlaps in their aims and functions are positioned as helpful due to their legitimating function for child psychotherapy. The partnership is therefore negotiated by taking up positions of ambivalent acceptance or superficial compliance. **Separate lives** implicitly resists discourses of the efficacy or helpfulness of medicating children by questioning the process of accessing knowledge about this area. This allows participants to present a neutral attitude to psychopharmacological practice, while also voicing critical attitudes towards it. This repertoire entails the adoption of strategies of avoiding direct engagement with questions about drug treatment, which minimise the potential for expressions of overt conflict. In both these first two repertoires, child psychotherapists can be seen as managing a dilemma of stake or interest in expressing their views on medication, by repudiating potential accusations of being automatically dismissive of or opposed to the medical treatment. Finally, **For the sake of the children** invokes complex layers of uncomfortable acceptance of and silent dissent towards the practice of treating children with psycho-pharmaceuticals. Portrayals of the psychotherapeutic process entail a deep resistance to the de-contextualising practice of medicating for symptom relief. Yet interviewees also position themselves as impotent and restricted in the face of the powerful meaning and authority accorded to medication. As such, participants take up a position of (mostly) silent challenge towards the use of medication.

The next chapter discusses the broader cultural and historical discourses that produce and are produced by these interpretative repertoires.

Chapter Five: Data Analysis II

Introduction

The interpretative repertoires identified in the previous chapter function to ward off potential accusations of prejudice against the medical model, and to navigate and minimise conflict between competing treatment paradigms. This chapter identifies broader historical, cultural and political forces that inform these repertoires, by delimiting available discourses of ADHD and its treatment. Participants' ways of talking about this subject can be understood as both reflecting and shaped by the historical identity of child psychotherapy in relation to psychoanalysis, psychiatry and dominant research and scientific paradigms. This analysis does not seek to judge the actual compatibility or validity of the two treatment models, but rather to explore the ways in which participants' accounts are informed and sometimes curtailed by dominant practices and discourses in the field of ADHD and child mental health.

Child psychotherapy, ADHD and paradigms of psychological distress

Child psychotherapy, like psychoanalysis, involves an ongoing dialogue between the role of experience and the role of biological endowment in producing human behaviour and subjectivity (Likierman and Urban, 2009). However, its emphasis on the centrality of the caregiving environment in facilitating emotional development and its privileging of individual subjectivity can both be understood as at odds with the increasing specificity of diagnosis and the search for the neurochemical origins of psychopathology which has characterised mainstream psychiatric research and practice over the last half century. Indeed, this 'rebiologizing' of psychiatry (Young, 1995, quoted in Rafalovich, 2001a, p.412) has been understood as a reaction to concerns about the legitimacy of psychoanalysis in the first half of the twentieth century. The attacks of the anti-psychiatry movement on the psychoanalytic use of a metaphorical language of illness to describe psychological distress ironically contributed to the impetus for mainstream psychiatry to evidence the physical origins of its theoretical constructs and to bolster its claims to scientific authority by the development of intricate technologies with which to visualise the brain (Thomas and Bracken, 2011). The replacement of the term 'Hyperactive reaction of childhood', which appeared in the DSM II in 1968, with 'Attention Deficit/Hyperactivity Disorder' in the

third edition in 1987 (Leuzinger-Bohleber et al, 2010) was indicative of mainstream psychiatry's move away from the psychoanalytic emphasis on the reactive nature of symptoms to social, psychological and biological factors, and towards the increasing categorisation of symptoms into distinct disorders, which went hand-in-hand with accelerating research into psychiatric drugs targeting specific neurochemical processes (Miller and Leger, 2003; Rose, 2007).

This historical backdrop of competing paradigms is matched by the contemporary setting. Over the last few decades, biological explanations for mental distress have increased in popularity (Schomerus et al, 2012), and the claim that diagnoses of psychopathology can be linked to organic correlates in the brain has produced an authoritative medical discourse, widely accepted as fact (Rose, 2007). Although in recent years a narrow, reductionist biomedical model of mental suffering has been increasingly challenged by voices both inside and outside the field of psychiatry, alternative frameworks have been understood as only paying lip service to a holistic approach while maintaining the status quo in practice (Ghaemi, 2009). Departures from the biomedical approach have been characterised as threatening to deny suffering individuals access to trustworthy, effective interventions on a par with physical health treatments (Craddock et al, 2008). In line with this, the field of ADHD is dominated by an authoritative, positivist medical discourse of ADHD as a predominantly organic 'illness', originating and detectable in the brain, and effectively treatable with stimulant medication. Despite acknowledgement within the field of brain imaging that as yet no evidence has been identified linking anomalies in the brain to ADHD, or indeed to any specific psychiatric disorder (Leo and Cohen, 2009), research into ADHD continues to be weighted heavily towards the search for physical evidence of its biological basis. Modern neuroimaging techniques such as computerised tomography (CT) and magnetic resonance imaging (MRI) enable researchers to compare the children's neuroanatomy in the search for evidence of differences that support the popular conceptualisation of ADHD as a primarily genetic, organic 'disease'. The assertion that ADHD is a biological phenomenon, with its roots in abnormal neurochemical processes has proved to be a persuasive and powerful one. The term ADHD is granted cultural privilege over alternative frameworks, not only within professional circles, but also in the ordinary talk and everyday language used in contemporary Western society (Danforth and Navarro, 2001). The dominance of medical over other

conceptualisations of ADHD is reflected in the proliferation of ‘neurodevelopmental’¹¹ teams or pathways in contemporary child and adolescent mental health services, in which children referred due to hyperactive, inattentive or impulsive behaviour are funnelled directly into assessments for ADHD. Both the language and processes of these neuro-developmental pathways, staffed primarily by medical and psychological staff, propel focus on external symptoms over emotions or relationships and hamper the expression of alternative narratives by constructing a primarily neuro-physiological understanding of externalising behaviour. These practices are driven by a powerful (although contested) discourse of stimulant medication as an evidence-based treatment for which the benefits outweigh the risks (Timimi, 2011).

An awareness of the appeal and potency of the medical discourse is reflected in Deborah’s description of parents’ preference for medical over psychotherapeutic treatment:

I mean obviously, you know, the, the parents are responsible for bringing children you know, so a parent who thinks I’m, I’m bothering to come to this clinic, you know, it’s taking up half of my day coming to this clinic and all I need do is pop the pill in the child’s mouth and I don’t need to do all this, well, you know, again one can see the temptation not to, to sort of see it through.

Deborah’s construction of parents choosing medication over psychotherapy as driven by the wish for a quick fix encapsulates the dual action of child psychotherapists’ narratives about this subject. On the one hand Deborah’s expression of empathy with time-poor families needing a solution is supportive of the offer of a medical intervention. Yet the image of pill popping and of parents’ reluctance to ‘see...through’ a longer or more taxing intervention is also implicitly critical, characterising this as an unrealistic and possibly irresponsible approach. The forces informing this narrative duality in each of the interpretative repertoires are explored in more depth below.

¹¹ ADHD is now listed under the new category of ‘Neurodevelopmental disorders’ in the DSM-V. This new category is said to reflect the growing body of scientific evidence supporting brain development correlates with ADHD’ (APA, 2013)

Keeping up appearances

The interpretative repertoire **A marriage of convenience** works to maintain the appearance of support for integrating psychotherapeutic and medical interventions. The importance of being seen to be open-minded about and accepting of medication is illustrated by the following extract, in which Laura conveys her sense of stumbling into dangerous territory when expressing anything other than supportive views of this practice:

L: *But I just, I do feel, a bit, that if it, if [medication] can provide a space that means that you can work, then it's got to be helpful. But I'm just not a hundred percent sure that it does. Then, then I can say exactly the same, other people would say exactly the same about psychotherapy. So, so on that note I ought to be tolerant [laughs]*

This extract speaks to a preoccupation with preserving an authoritatively sanctioned mandate to practice in this field. The presentation of the two interventions as congruent and mutually supportive, at least in principle, can be understood as adherence to a public message of compatibility, in exchange for a truce on in depth probing into issues of effectiveness. Concerns about others' perceptions of the effectiveness and legitimacy of psychotherapy can be understood as linked to the relative powerlessness and marginality of the profession of child psychotherapy with mental health provision and the increasing pressure on psychoanalytic psychotherapists to create an authoritatively ratified body of evidence for their treatments.

Child psychotherapy is one of the least frequently represented professions in child and adolescent mental health services (CAMHS) in the UK (NHS Benchmarking Network, 2013). Long-term underfunding, in addition to recent pressure on NHS Trusts to make financial savings have led to budget cuts in CAMHS despite increasing numbers and complexity of children referred (Association of Child Psychotherapists, 2014). This has been addressed in part by downgrading senior non-medical clinicians such as consultant child psychotherapists. At the same time, cost, speed of delivery and measurability have become major considerations in planning and commissioning services. Policy developments such as the National Service Framework for Children (Department of Health, 2004) and the introduction of Children and Young People's

Increasing Access to Psychological Therapies (CYP-IAPT) have intensified the demand for mental health interventions with children to be ratified under narrow criteria of evidence. The 'evidence-based' discourse, which Holmes et al argue has 'colonised' the health sciences over the last three decades accords power and trustworthiness to clinical interventions for which links between actions and outcomes can be demonstrated via large-scale experimental design, most commonly the randomised controlled trial (2006, p.181). These research parameters, which are purported to ensure both quality and cost-effectiveness, are held to be the ideal conditions for producing trustworthy scientific knowledge about therapeutic effectiveness, and therefore have powerful academic and political status (Midgley, 2004). The power of this hegemonic knowledge discourse is evident when Karen says of her patients:

K: They do, they do become, I suppose it's just much more integrated, just like being with somebody who's quite fragmented and all over the place, and then they sort of feel a bit more, I was going to say gathered up, that's not very scientific is it?

In this extract the language of containment ('gathered up'), which is so central to the psychoanalytic literature (e.g. Bion, 1962), is not considered to be adequately 'scientific'. This highlights the delimiting of the boundaries of knowledge and authority within a political climate that privileges a particular type of scientific endeavour. Indeed, the participants' (and my own) use of the acronym 'ADHD' to define a particular group of children already positions child psychotherapists within the paradigm of 'biological psychiatry', whose status as a credible, 'scientific' profession is bound up with its project of producing experimental evidence of the neurophysiological origins of psychopathology (Rose, 2007, p.188). Historically, child psychotherapists have resisted straightforwardly engaging in mainstream experimental outcome research, arguing that its assumptions pose methodological, epistemological and practical challenges to investigating process and outcome with human subjects (Urwin et al, 2009; Rustin, 2009). However, the absence of a large body of research fitting into this dominant research paradigm, and the bias within mental health service provision towards psychopharmacological and behavioural interventions that have been extensively researched within this paradigm, has fuelled doubts about child psychotherapy's effectiveness and scientific credibility. Compliance with the language and practices of disciplines deemed trustworthy and authoritative is one method of bolstering credibility for a discipline insecure about its own scientific status (Boyle, 2011). Laura's presentation of psychotherapy as producing 'real change'

that takes place in '*the corpus callosum*' (see p.59), appeals to the intertwined discourses of the brain and of the evidence-base, which hold that the most authoritative evidence for the effectiveness of any intervention lies in the capacity for its activity to be visualised in the physical organ of the brain. Psychotherapy's legitimacy is strengthened not only in its congruence with the action of medication but also in its capacity to be directly observed, rather than described or imagined. As such Laura's suggestion that greater fluency in the language and theory of physiology '*might help us in our in our profession*' (see p.61), can be understood as co-opting the vocabulary of the physical, observable body and brain as an 'alibi' (Aflalo, 2009, p.31) for child psychotherapy's credibility in a field in which it is relatively lacking in power. As such, keeping up appearances of legitimacy and compatibility with dominant discourses of ADHD can be understood as one function of the ambivalent acceptance and superficial compliance found in child psychotherapists' ways of talking about their work with children medicated for ADHD.

Avoiding confrontation

The interpretative repertoire **Separate lives** works to simultaneously voice and deny challenges to the practice or efficacy of prescribing medication for children diagnosed with ADHD, by undermining the possibility of producing certain knowledge about this subject. This discursive duality can be understood as produced not only by the dominance of the medico-neurological discourse of ADHD, but also by attempts to avoid identification with attributions of blame and responsibility implied by rejecting biological explanations for distressed and distressing behaviour.

By invoking the experimental language of tracking and '*monitoring*' (Olivia) when asserting their inability to reliably access knowledge about the impact of medication, participants co-opt the powerful evidence-based discourse to implicitly resist medical hegemony in this area. The foregrounding of the impossibility of reliably disentangling cause and effect resists some of the legitimating force of the practice of medicating children diagnosed with ADHD by implicitly challenging the powerful discourse of medication's effectiveness, which is so central to ratifying the medico-neurological discourse of ADHD as a biological illness (Gunter, 2014). At the same time, the adoption of a 'not-knowing', reflexive stance, which resonates with the clinical discourse of psychoanalysis (Staufenberg, 2010), also cultivates the presentation of uncertainty

which positions participants as agnostic on the subject. This agnosticism allows participants to problematise the use of medication without taking up an explicitly or dogmatically critical position. This is exemplified in the following extract from Deborah:

- D: *Um, you know, I've, I've seen children vastly improved by, by being much steadier on medication. Um, but I've also, you know, I also don't know um, what it is that causes the improvement, is it the drug, is it the attention?*

By questioning the validity of relating changes straightforwardly to medication, and raising the possibility that the child's environment or the psychological impact of the experience of receiving a diagnosis and medication could be responsible for these changes, Deborah draws attention to the impact of the child's context on their behaviour and constructs the child's difficulties as potentially linked to their environment. This poses an implicit challenge to the practice of medicating the child for a 'disorder' when the source of their difficulties is understood as being in the environment rather than simply in the individual child. A further excerpt from Deborah's interview throws some light on the necessity for the indirectness of this resistance to the medico-neurological discourse of ADHD, by pointing to issues of moral responsibility raised when children's behaviour is linked to the caregiving environment:

- D: *Obviously, you know, once we see a child, they've been in that state, we don't know how much the parent's response is, you know, because they're fed up with the child being like this. Or how much is causal and, and, you know, I think that one can too much as a sort of child psychotherapist see all of the sort of children's you know difficulties as, as being to do with sort of their parents' and my, my youngest child, my David, um, you know, has been going to the therapy for a number of years which has done him sort of the world of good and do I think that, you know, he went because I had failed as a parent in some sense or you know, I mean the sort of, I'm, I'm reluctant to have this sort of idea that you know children need help because they've got lousy parents. But, sort of, I do also sort of somewhere you know have questions about that.*

In the extract Deborah is negotiating the morally saturated discourse of parent blame. She works hard to avoid taking up this discourse, highlighting her uncertainty about cause and effect, her own status and fallibility as a parent and her lack of enthusiasm for constructing children's distress as straightforwardly caused by their parents. Her acknowledgement of the potential for her professional background to predispose her to

automatically treat children's difficulties as products of their parenting experiences simultaneously invokes and repudiates potential judgements of child psychotherapists holding a blinkered, parent-blaming stance. This speaks to the complexities inherent in the attempt to re-contextualise symptoms of ADHD as linked feelings and experiences, while also avoiding the adoption of a reductionist discourse of parent blame sometimes associated with the history of psychotherapeutic interventions (Timimi, 2009). In acknowledging that parental behaviour could be a consequence rather than a cause Deborah draws on what Boyle has termed a 'safety behaviour' (2011, p.30) used by psychiatrists and psychologists to avoid acknowledging the importance of context in producing mental distress. Biological explanations for emotional distress have been said to sanitise and simplify by avoiding the messy, value-laden questions of blame and responsibility (Rapley, Moncrieff et al, 2011) In contrast, constructions of hyperactive, inattentive or impulsive behaviour as an understandable and meaningful consequence of stressors within the child's environment do the opposite, by raising complex questions of moral responsibility which clash with biological psychiatry's conceptualisation of deviant behaviour as a sign of meaningless internal dysfunction attributable primarily to organic defects (Boyle 2011). The implication of a 'non-human agent' (Rafalovich, 2001b, p.378) in the appearance of unwanted or unpleasant behaviour in children neatly sidesteps questions of individual, familial or societal moral accountability that are inevitably raised by the treatment of ADHD symptoms as expressions of understandable distress. Rafalovic (2001a) argues that the survival of the psychological-behavioural model of ADHD alongside the medico-neurological one is linked to its tacit compliance with the fundamental tenets of mainstream Western psychiatry. By treating symptoms as secondary reactions to unspecified organic deficits, behavioural models of ADHD can justify a focus on the qualities of children's and parents' social interactions without undermining the biological discourse of ADHD. Similarly, child psychotherapists' adoption of an explicitly agnostic (but implicitly critical) position on the efficacy and use of medication can be understood as functioning to avoid confrontation with a moral language of parental agency and responsibility for children's behaviour.

Resisting blame

The construction of ADHD symptoms as meaningful communications of distress related to environment or experience implicitly challenges the de-contextualising action of the

medical model of ADHD as a neurological illness whose symptoms can be eradicated with medication. However, in the repertoire **For the sake of the children**, although psychotherapy is positioned as seeking to understand and contextualise rather than eradicate children's troubling behaviour, medication is constructed as a necessary measure with the power to relieve despairing parents and carers. This repertoire therefore resonates with both a moral discourse of emotional suffering as produced by social context, and a neoliberal discourse of individual responsibility for adhering to the norms of health and wellbeing. This duality highlights interviewees' negotiation of conflicting moral narratives regarding ADHD. As such the action of participants' talk in this repertoire can be understood as resisting polarised discourses of individual or parental blame for the development of ADHD symptoms.

This duality is exemplified in the following extract, in which Rita shifts the locus of difficulties out of the child and into the '*setting*', without directly challenging the practice of intervening with medication:

R: *I mean sometimes parents are in very difficult situations, so schools, social workers, they do demand medication because the child seems impossible in those settings. Like let's say, uh, there is a serious problem, illness in a sibling and the parents are attending, uh, regularly to hospital or admissions with that child and there's a lot of, you know, issues around that. So with an ADHD child the system would demand medication immediately because the parents cannot support the child.*

In reluctantly approving the use of medication, in Rita's words, to make the child '*a bit more manageable for drained parents or, uh, school to keep the child*', a post-industrial discourse of deviant behaviour as subject to individual psychological or medical intervention is invoked. Rapley et al (2011) argue that the choice to characterise child behaviour in medical terms is itself a moral choice, which locates problems and deficiencies inside the individual child rather than in the system around them. This discourse normalises the use of medication to help children conform to educational, familial, psychological or medical expectations. It can be traced through the history of the use of stimulant medication to intervene into children deemed hyperactive, which has its roots in Charles Bradley's 1937 discovery that administering Benzedrine to child patients of normal intelligence who were unable to function adequately in mainstream education noticeably improved their academic performance and social skills (Rafalovich, 2001a). In Foucault's terms Bradley was acting to facilitate his young

charges' obedience to the 'imperative of health' (Foucault, 1991, p.277) which is required in a modern culture in which adherence to public health objectives set and facilitated by the state is understood as the moral duty of all. Deborah encapsulates the normalising power of this discourse of medication as an acceptable means of maintaining a healthy body when she states:

D: *[Taking medication] becomes much more like sort of you know, this is what you take in the morning and you brush your teeth and you take your tablet and you know, it doesn't, it doesn't necessarily cover any sort of stigma.*

The construction of medication as an unpleasant but necessary measure required to enable poorly functioning children meet societal demands resonates with this post-industrial Western discourse in which troubled or troubling behaviour, thoughts and emotions are understood as produced by deficiencies within individuals' brains or minds, which are in turn considered to be the most appropriate targets for intervention (Boyle, 2011). Indeed, the 'intellectual technology' (Rose, 1998, p.10) of the psych-professions (psychiatry, psychology, psychoanalysis, psychotherapy) is predicated on this construction of people as individuals whose conduct, inner worlds and relationships can be productively administrated and regulated by expert practices within institutions such as child mental health teams. In the following extract, Rita reflects on the complexities inherent in being a '*professional*' aiming to alleviate children and families of their problems:

R: *[R]eally to consider everyone in child's environment as partners, not to think that professionals are one group and child and mother is another group and mother is the responsible person of the child's behaviour, which I don't know if it's cultural or I don't know what is it, but this is the most painful bit when it happens in the team, because then, um, it, it, if there is a lot of splits then in the team, I mean communication breaks down...I think the problem, uh, often is not accepting the problems in the parent. Thinking that the parent as an adult should be able to do this, even though you say this parent has herself, you know, serious mental health problems and you advocate sometimes that she needs to be receiving social support as well or psychological support, which is very limited unfortunately in adult services, and social services are not very keen to follow those routes, you know, so those are often the problems. You know, there are, then the system needs support, not only the child.*

Rita's account suggests that polarised attributions of blame are produced in the context of deprivation, power struggles and limited resources, which exacerbate tendencies for teams to atomise into professional groups and draw on discourses of blame and

responsibility. In her emphasis on the impact of failures to adequately support adults as well as children, she navigates a course between the discourse of mother-blame and the discourse of individual pathology. Similarly, in remarks made towards the end of our interview, Karen alludes to the influence of institutional practices on the rise in diagnoses of ADHD:

- K: *That's a whole other angle about expectations of boys I think...I don't know you know, I think sometimes, you know, boys are done a real disservice, you know, they sit and wiggle in class and they've instantly got ADHD rather than just that they're five and actually testosterone's beginning to kick in at that age isn't it, don't they, isn't it five or six or something?*
- I: *Yeah, something like that yeah.*
- K: *Or something, I don't know but, you know, and they need to move around or they're just going to function differently So those sort of things are really grossly unhelpful um in our schooling really.*

Here Karen explicitly draws on a socio-cultural discourse of ADHD which attributes the rise in displays of hyperactive, inattentive or impulsive behaviour to contextual factors in Western culture such as the extension of formal schooling to younger children (Timimi, 2009). Like Rita, by constructing the 'system' as a potential target of intervention, Karen foregrounds the role of broader social and cultural forces in producing unwanted behaviours in children, thus resisting the location of blame or pathology in both parents and children.

Summary

In this section I have shown how the boundaries of what can and cannot be said about combining psychotherapy and medication are delimited by concerns about power and legitimacy within the terrain of child psychotherapy and child mental health more broadly. Participants' enactment on a site of uneven power relations informs the adoption of ambivalent acceptance of and superficial compliance with an authoritative medical discourse of ADHD. Interviewees avoid or minimise conflict between medical and psychoanalytic approaches in order to negotiate this power differential, and to avoid espousing a reductive discourse of parent blame. This produces the discursive duality identified throughout the interview material, in which the overt message of compatibility between psychotherapy and medication is undercut by implicit or indirect resistance to this practice, and by accounts of clinical experience.

In the next and final chapter, I explicate the findings produced by this research, linking them to the existing literature and to the field of child psychotherapy and ADHD.

Chapter Six: Findings and Conclusions

This concluding chapter summarises the findings from this research project and discusses their implications for the field, for practice and for future research.

Findings

Three central, overlapping findings emerged from this research into child psychotherapy with children who are medicated for ADHD:

1. There is an unacknowledged paradigm clash between psychoanalytic and medical models of ADHD.

In their accounts, child psychotherapists construct ADHD as distress rather than illness, and resist the location of pathology within the child. Despite this they adopt an agnostic position in relation to the illness paradigm, and avoid directly addressing potential conflicts between the two treatment approaches. This agnosticism functions to demonstrate open-mindedness towards the dominant medical model and to avoid alignment with a reductive discourse of parent-blame.

2. There is a dissonance between a proclaimed complementarity between psychoanalytic and psychopharmacological interventions, and an absence of mutually enriching collaboration in practice.

Participants consistently emphasised the mutual benefits offered to one another by psychoanalytic and psychopharmacological interventions. However in their accounts of clinical practice, medication was portrayed as having little or no effect on the child or the therapeutic process, and fruitful collaboration between the two approaches was rare. This dissonance is understood as adherence to a legitimising message of compatibility between psychotherapy and medication.

3. Psychotherapists appear to be ambivalent and only superficially accepting of and compliant with the medical model of ADHD.

In working with children who are medicated for ADHD, child psychotherapists are located in a site of uneven power relations. Positions of ambivalent acceptance of and superficial compliance with psychopharmacological treatment are adopted in order to repudiate accusations of being automatically opposed to the use of

medication, and to preserve an authoritatively sanctioned mandate to take part this field.

Conclusion

The value of a multi-perspective, biopsychosocial model of ADHD is widely supported in the psychoanalytic literature, which emphasises the potential for psychopharmacological and psychotherapeutic approaches to ADHD to be mutually enriching (Nathan, 1992; Sweeney and Tatum, 1996; Orford, 1998; Gilmore, 2000; Wright, 2006; Carey 2010; Leuzinger-Bohleber et al, 2010; Gensler, 2011). However the findings from this research provide a different perspective on the interdisciplinary practice of combining psychotherapy and medication. Although participants echoed the view of medication and psychotherapy as well-suited partners, their narratives were characterised by ambivalent acceptance of or superficial compliance with this position, and successful cross-disciplinary partnerships were rarely evident in descriptions of clinical practice.

In examining the power structures that limit available discourses about ADHD, this research understands expressions of support for integration between the two treatment models as partly oriented towards demonstrating compliance with a more powerful partner. Medico-neurological hegemony within the field of ADHD, the avoidance of polarising attributions of blame and the marginalised status of child psychotherapy are identified as potential barriers to acknowledging conflicts between medical and psychoanalytic approaches or expressing direct challenges to the theory and practice of medicating children.

These findings therefore add to the literature by proposing that child psychotherapists' critical engagement with the field of ADHD can be stifled by the normalising power of biological psychiatry and the relatively powerless status of child psychotherapy in relation to mainstream biological psychiatry. Cross-disciplinary dialogue risks becoming unidirectional, with child psychotherapists acknowledging the potential enrichment of their profession by findings from neuroscience and biological psychiatry, but struggling to offer their particular perspective to both question and enrich the neuro-biological perspective on emotional distress. The compliant and avoidant aspects of child psychotherapists' collaboration with the medical approach have the

potential to endanger creative, productive interdisciplinary exchange by curtailing open exchange and debate about the range of approaches to ADHD, and the different ways children can be understood and helped.

Implications for practice

There are no easy solutions to the problems thrown up by the delimiting action of powerful discourse on practice and subjectivity. However this research respectfully calls for practical action that aims to help child psychotherapists mitigate the disempowering and normalising effects of medical hegemony in the field of ADHD in the interests of broadening public and professional attitudes to challenging behaviour and emotional distress. To this end, I make the following suggestions:

Developing a more equal partnership

Around 80% of CAMHS in the UK provide a specialist ADHD service (NHS Benchmarking Network, 2013). The introduction of 'neuro-developmental' pathways to assess and treat these children is held to be good practice, which provides families with reduced waiting times and a specialist service (House of Commons Health Committee, 2014). However in practice this produces a process of referral screening, which filters children referred with hyperactive, inattentive or impulsive behaviour directly into specialist teams with a focus on making or excluding this diagnosis. Although the NICE guidelines (2008) recommend that ADHD teams should be multi-disciplinary, paediatricians and child psychiatrists are the only named professionals in the guidance and ADHD teams are usually lead by medical staff. As well as compounding medical hegemony in the field, these processes reduce opportunities for children, parents, teachers and clinicians to consider other explanations for presentations of hyperactive, inattentive or impulsive behaviour. Giving more prominence to the recommendation that teams assessing and treating ADHD are multi-disciplinary, including all professionals represented in core CAMHS¹², would provide a more diverse range of clinical approaches to referred children. As well as potentially balancing the dominant

¹² One of the participants in this study had been involved in the development of such a team, which she and her colleagues had initiated in response to the level of complexity observed in children referred for ADHD. She reported that this resulted in better dialogue between psychiatrists and other clinicians regarding these children and a wider range of interventions being offered. This was the only participant who could give concrete examples of joint working and thoughtful engagement with the medical side of the treatment.

medico-neurological discourse of ADHD, offering children presenting with hyperactive, inattentive or impulsive behaviour an assessment in a truly multidisciplinary context would facilitate the joint construction of an understanding of the child's difficulties most helpful to that child and their family at that time. This would conform more precisely to the government's principles of informed patient choice and service-user consultation than the top-down application of a rigid diagnostic framework.

Creating opportunities for genuine critical engagement

a) Training and continuing professional development (CPD): Authentic critical engagement with psychiatric research and practice could be facilitated by improving child psychotherapists' sense of security about their knowledge of these practices. Including prequalification and CPD opportunities for critical readings of both 'evidenced-based' research on ADHD and psychoanalytic formulations of hyperactivity, inattentiveness and impulsivity would provide child psychotherapists with safe, stimulating opportunities to learn about and question both dominant and alternative conceptualisations of ADHD. It is hoped that this would equip child psychotherapists with more confidence to engage openly with the debate about ADHD.

b) Busting myths: It is notable that in a volume of essays challenging the medicalisation of suffering by contemporary psychiatric theory and practice, psychoanalysis is only mentioned in the context of charging Freud with the responsibility of conflating psychological and physical ailments, and spawning the individualising practices of the psy-complex (Rapley et al, 2011). Despite the fact that the history and practice of child psychotherapy is steeped in a nuanced understanding of the continuity between normality and pathology (Freud, 1965) and the impact of relationships on mental and emotional life (Fonagy, 2010) child psychotherapists still struggle to divest themselves of a reputation for mother-blame and patriarchal pathologising. While the absence of psychoanalytic researchers and practitioners in the field of ADHD is beginning to change (Leuzinger-Bohleber et al, 2010), child psychotherapists could benefit from joining forces with other disciplines critical of the biomedical approach in speaking out about their contribution to the understanding of children diagnosed with ADHD. As Boyle suggests, the 'novel and potentially hazardous' task of challenging the language of individualised pathology used to describe mental distress may be 'best done in the presence of allies' (2011, p.41).

c) *Valuing qualitative research*: The profession of child psychotherapy is already active in increasing its research output and the research literacy of its members, and most trainings are now at doctoral level. Impressively, in the face of many methodological and practical barriers, funding is beginning to be won for large RCT projects investigating psychotherapy outcomes for children and adolescents (e.g. Goodyer et al, 2011). The value of these undertakings for the profession cannot be overstated. However, as findings from this research suggest, the need to engage with this particular scientific paradigm can be felt to be an unpleasant necessity rather than truly enriching to child psychotherapists and the children with whom they work. Training organisations seeking to enable trainees to undertake clinical doctorates have struggled to balance training needs with the provision of a research curriculum that does not feel too divorced from core clinical work. Tensions between research and practice in child psychotherapy have been aptly characterised by Midgley as the difficulty of sailing between the authoritative yet impersonal ‘Scylla of large-scale quantitative research’ and the psychoanalytically relevant yet methodologically and politically marginal ‘Charybdis of the clinical case study’ (2004, p.2). Midgley proposes qualitative research as a middle way between these opposing poles and notes that the development of clinical doctorates in child psychotherapy is beginning to generate more small-scale qualitative studies within the profession. Yet between April 2015 and April 2016 only one publication of a piece of qualitative research appeared in the *Journal of Child Psychotherapy* (Whitefield and Midgley, 2015). The profile of qualitative research could be raised by the development of a working group for qualitative research within the Association of Child Psychotherapists, to pool and collate knowledge produced by doctoral theses and stimulate applications for more ambitious qualitative research proposals. Offering CPD on the use and applications of qualitative research methodologies could be a further step towards facilitating more child psychotherapists to take an active part in ongoing dialogue between psychosocial academic research and psychoanalysis¹³. Valuing qualitative research skills as well as

¹³ In recent years researchers have acknowledged psychoanalysis’s capacity, when used carefully, to enrich both the interview process and the analysis of data by attending to the emotional factors inherent in inter- and intra-personal processes (Hollway and Jefferson, 2000; Kvale, 2003). Child psychotherapists’ rigorous training in the use of subjectivity makes them well-suited to engaging in research aimed at grappling with the diversity and shifting subjectivities of human subjects (Rustin, 2009). Parallels between psychoanalytic interpretative techniques and the qualitative data collection process can be found in Rustin’s account of psychoanalysis’s ‘self-critical attitude to clinical data’ (ibid, p.44). The discipline of developing analytic codes and categories from the data, while striving to avoid pre-conceptions, is comparable to the paradoxical struggle in psychoanalysis to forget what is known and to allow a new, previously unknown pattern to emerge (Bion, 1967). The requirement for the psychoanalytic clinician to be aware that insights

challenging the construction of 'evidenced-based' methodologies as value-free and objective is one way to support the emergence and acceptance of a more diverse range of methods for producing knowledge and understanding of children and young people.

Alternative ways to do the best for children

a) Improving inter-agency dialogue: The acceptance of medication as a desperate measure in the absence of good enough social care or adult mental health provision foregrounds systemic failures in adequately providing good-enough environments to facilitate healthy emotional growth in vulnerable children. In the context of limited resources and high caseloads, distressed or distressing behaviour in children tends to become atomised into a particular kind of 'problem': a parenting problem, a learning problem, a mental health problem. These problems are then pushed around to their respective agencies (social care, school, CAMHS) who are expected to solve them. The well-known label of ADHD firmly identifies this problem as belonging to CAMHS, and precludes opportunities to develop a more nuanced, complex understanding of the factors contributing to children's presentation of hyperactive, inattentive or impulsive behaviour. While much-needed additional funding to education and social care might reduce some of this desperation, this is unlikely to become available in the current economic and political climate. A more modest attempt to address these issues could be made by providing training and education on the range of understandings of this presentation in children to teachers, social workers and foster carers, and by offering pre-referral multidisciplinary consultation to professionals working with children presenting with hyperactive, inattentive or impulsive behaviour. Linking these initiatives to a possible reduction in referrals could support applications for them to be included in CAMHS commissioning budgets.

b) Providing opportunities to reflect: Within the over-stretched, emotionally-demanding context of child mental health provision, the biomedical discourse of ADHD offers comforting certainty both to those seeking help and to those offering it. As Danforth and Navarro observe, in everyday language constructions of ADHD, 'the vague and troubling difficulties of lived experience are put into consoling and hopeful order by the authoritative medical discourse' (2001, p.185). Moral narratives of parental

may be 'overvalued ideas' in which facts are 'forced to fit a hypothesis or theory which the analyst needs for defensive purposes', rather than 'selected facts' which emerge organically facilitated by suspension of doubt (Britton and Steiner, 1994, p1070) is good preparation for the rigours of qualitative data analysis.

responsibility are equally reductionist and polarising in their neglect of broader social, cultural and economic factors in producing particular styles of parenting. The provision of a reflective space for child mental health professionals to process strong feelings about the children, families and colleagues with whom they work, could mitigate the impulse to defend against uncertainty or helplessness by locating pathology within the child or by blaming parents.

c) Politicising children's mental health: One potential antidote to the reductionist discourses of ADHD as medical illness or ADHD as parental failure is the foregrounding the impact of social and political factors that can create adverse environments and impair good-enough parenting. As well as campaigning for greater recognition and funding for child mental health services, child psychotherapists should also be vocal about their understanding of the impact of austerity measures and welfare cuts on the emotional and mental health of the children and families they are tasked with helping.

Critical reflections on research

In Chapter Four (pp.51-53) I described how systematic examination of and reflection on my experience of the research process helped to crystallise aspects of the data analysis. The initial theme *Communication breakdown* was produced by my reflections on feelings of awkwardness and discomfort when I attempted to bring the subject of medication into the conversation, and the dissonance between this discomfort and interviewees' enthusiasm about participating in a project investigating the subject of combining psychotherapy and medication. I also described how my decision to build on the initial thematic analysis using discourse analysis was influenced by my reflective journal. By dedicating a space to freely recording and reflecting on my own and the interviewees' responses to the process of gathering and analysing my data, I was able to identify preoccupations with how and by who participants' words on this subject would be heard and interpreted, leading me to turn to a discursive analysis to investigate the performative aspects of the interview material.

The findings produced by this research have had a significant impact on my own experience of and attitudes towards clinical work and research, and more broadly towards taken-for-granted ways of talking and thinking about mental health. Throughout the long process of analysing and writing up my findings, I found myself

reflecting on my initial research proposal, and my use of authoritative, traditionally empirical language and grammatical constructions, such as referring to the 'prevalence' and 'aetiology' of ADHD and the exclusive use of the passive tense. I believe that this was driven in part by a wish to lend authority and credibility to my own research endeavour, and to be seen as a child psychotherapist who could take part in mainstream scientific exchange. In doing this, I minimised or excluded my own doubts or uncertainties about the use of the diagnostic category of ADHD and produced a simplified yet authoritative-sounding preliminary literature review. The arduous process of studying the ambiguities and contradictions in the participants' accounts of the research process enabled me to write about this area in a more nuanced fashion, less hampered by concerns about complying with a positivist empirical model. It has also led me to question the language and assumptions used routinely in the clinical setting in which I work, and given me the confidence to begin dialogues about this with colleagues from other disciplines.

Finally, the moral and political issues raised by this research have made me aware of the privilege and responsibility that comes with being granted access to the personal, often private struggles of children and families. It has caused me to assess afresh my duties towards these families in the political as well as the personal sphere, and to ponder seriously on how best to join with them in speaking and taking action on how our society contributes to and copes with emotional distress.

Study limitations

As a small doctoral thesis undertaken alongside an intensive clinical training, there were many limitations to this research project.

The small sample number of six participants means that the results cannot be generalised. Furthermore, those who participated were a self-selecting group. All the participants expressed their support for the project of developing knowledge about child psychotherapy and ADHD. This stance is likely to have influenced their attitudes to the research subject, and it is possible that interviews with child psychotherapists without a particular interest in ADHD may have produced quite different results. For example, participants with less concern for building bridges between psychiatric and psychoanalytic viewpoints may have produced more forthright or less ambivalent

narratives about this subject. Furthermore, all the child psychotherapists interviewed for this research were women, something that reflects the gender bias within the profession. Although the intersectional nature of gender means that it is not possible to say what differences may have been produced by a mixed gender group of participants, including male participants may have provoked alternative perspectives on the subject.

The majority of the children discussed in the interviews were children with complex experiences of separation, deprivation or abuse. This probably reflects the type of population referred to child psychotherapists, many of whom work in specialist Looked After Children teams or tier 3 CAMHS with high thresholds for disturbance levels. It may also reflect the features of children most likely to be offered both medication and psychotherapy. The nature of the children discussed means that this project gleaned little understanding of child psychotherapists' clinical formulations about children diagnosed with and medicated for ADHD without obvious stressors in their current or past environments.

I am also aware that in only interviewing child psychotherapists, this research excluded the voices of psychiatrists from the findings. Gathering data on psychiatrists' experience and understanding of the process, aims and impact of referring medicated children for individual psychotherapy would have produced a richer data set and perhaps results with greater generalisability. Within the time frame of this research I was also unable to triangulate my findings with other sources, or seek participant feedback on them. This too could have enhanced the credibility of the results (Guba and Lincoln, 1981).

However, rather than focussing on this post-hoc implementation of verifying strategies, I followed Morse et al's recommendation that the data analysis is presented in such a way that the quality of the methodological and analytic decisions made during the research process can be identified and interrogated (2002). The aim of this research was not to posit a single unquestionable truth, but to describe and explore one possible version of reality produced by the conversations that took place between me and six other people, in the hope that the findings would trigger further ideas for pursuing knowledge about this area. My epistemological stance acknowledges not only the partialness of all attempts to describe and understand reality, but also the impact of the researcher's preconceived ideas and experiences as well as her presence, words and

actions on the research process. Throughout this thesis I have attempted to show my awareness of the co-constructed nature of knowledge and the nuances that reflections on my contribution have brought to my understanding of the research subject.

Recommendations for future research

As a preliminary, exploratory project investigating a subject previously unexplored using empirical methods, there are numerous potential directions to follow in extending, expanding and challenging this research.

One means of including the voices of psychiatrists and other mental health professionals could be to investigate multidisciplinary exchanges as they take place in child mental health teams. Analysing the nature of clinical discussions between different mental health professionals would be one way to further interrogate the discursive resources that are drawn on by clinicians in cross-disciplinary exchange and the broader social, cultural and political dynamics that inform this.

Important aspects of the analysis of the data from this research were the difficulty keeping in mind the subject of medication, and participants' construction of medication as having little impact on the therapeutic process, despite their assertions of interest in and support for the medical treatment. I have understood this dissonance as produced by issues of power and legitimacy that delimit available discourses about ADHD and medication. However this finding could be further explored or challenged by examining the process of psychotherapy with medicated children from a different angle and with a different methodology. For example psychotherapists' process notes for medicated and non-medicated children could be compared, or interviews could be carried out with both medicated and non-medicated children about their experiences of psychotherapy. This could also contribute further to the incipient empirical literature on the psychoanalytic understanding of children presenting with hyperactive, inattentive or impulsive behaviour. Alternatively, as discussed in Chapter Two (pp.25-26), there is a wealth of published case study material available on conducting psychoanalytic psychotherapy with children medicated for ADHD. This research could be extended by a further discourse analysis of these texts.

Finally, the findings from this research indicate that discourses of parenting norms and moral responsibility are influential in constructing professional attitudes to the understanding and treatment of ADHD. The discursive practices of families navigating both clinical and everyday discourses of ADHD has been examined by a few authors (Malacrida, 2001; Danforth and Navarro, 2001), but as far as I am aware only one paper analysing the conversation during a diagnostic session has been published (McHoul and Rapley, 2005). Additional research exploring the discursive interactions between professionals and service users in assessment settings could illuminate further contemporary constructions of mental health difficulties and the impact of powerful institutions and practices both on those seeking and on those offering help.

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Appendix 1: Ethical approval from Birkbeck, University of London

From: Ursula Brown u.brown@slc.bbk.ac.uk
Sent: 23 May 2011 11:18:15 GMT+01:00
To: Sarah Peter
Cc: SSHP Ethics sshpethics@bbk.ac.uk
Subject: Ethics Proposal 2011-0026 PETER, Sarah

Date of submission: 28.3.11
Investigator: Sarah PETER
Reference n.: 2026-0009
Title of Project: An investigation into how child psychotherapists understand and treat children who are medicated for ADHD

Dear Sarah,

The School of Social Sciences History and Philosophy Ethics Committee has scrutinised this proposal and has given it ethical approval.

Please keep this message as official record of the approval for future reference. We will be happy to provide a formal letter of approval upon request.

Good luck with the research.

Ursula

Ursula Brown
Assistant School Manager
School of Social Sciences, History & Philosophy
Birkbeck, University of London
(on behalf of the SSHP Ethics Committee)

u.brown@bbk.ac.uk

Appendix 2: Information sheet given to interviewees

Information Sheet

Department of Psychosocial Studies
BIRKBECK
University of London
Malet Street,
London WC1E 7HX
Tel. 020 7631 6000

Title of study:

Exploring child psychotherapists' understanding and treatment of children who are medicated for ADHD

Researcher:

Sarah Peter

This study is being done as part of my clinical doctorate in child psychotherapy in the Department of Psychosocial Studies, Birkbeck, University of London. The study has received ethical approval.

This study wants to explore the ways in which child psychotherapists understand and work with children who are medicated for ADHD, and how child psychotherapists position themselves in relation to knowledge about this area.

If you agree to participate you will agree a convenient time and place for me to interview you for about an hour. You are free to stop the interview and withdraw at any time. A code will be attached to your data so it remains totally anonymous.[#] The analysis of our interview will be written up in a report of the study for my degree. You will not be identifiable in the write up or any publication which might ensue.

You may be asked for feedback on the process and results of this study at a later date, although this will not be compulsory.

The study is supervised by Viviane Green who may be contacted at the above address and telephone number.

Appendix 3: Consent form

Consent Form

Department of Psychosocial Studies
BIRKBECK
University of London
Malet Street,
London WC1E 7HX
Tel. 020 7631 6000

Title of study:

Exploring child psychotherapists' understanding and treatment of children who are medicated for ADHD.

Researcher:

Sarah Peter

I have been informed about the nature of this study and willingly consent to take part in it.

I understand that I must not reveal any names or identifying information when discussing clinical material.

I understand that the content of the interview will be kept confidential.

I understand that I may withdraw from the study at any time.

I am over 16 years of age.

Name

Signed

Date

Appendix 4: Information regarding NHS ethical approval

From: Eboda, Enitan
Sent: 15 April 2014 09:43
To: Peter, Sarah
Subject: Research proposal - query about ethical approval

Sarah,

Please accept my apologies for the late response. Your e-mail arrived while I was on extended sick leave and it has taken a while to clear the backlog. However, you are correct in that NHS permission for this study is not required, as you are not intending to recruit participants through the NHS. This means that no further action is required from this Trust before you commence the research. If you require further information in the meantime, please let me know. Good luck with your research.

Kind regards,

Enitan Eboda (Ms)
Research & Development Co-ordinator, South-West London and
St George's NHS Trust

Appendix 5: Interview schedule

Interview schedule

- Can you tell me a bit about your experience of working with a child who was medicated for ADHD?
- Can you tell me a bit about the process of how you might begin seeing a child who is on medication for ADHD?
- Does the fact they are medicated affect the treatment/aims?
- Do you notice any differences in child in therapy once they are taking medication?
- Technical issues?
- How do you feel about working with a child on medication?
- What is the psychotherapist's role when working with a child who is medicated for ADHD?
- What do other professionals think or feel about giving psychotherapy to a child on medication?
- Why do/did these children receive medication and psychotherapy, rather than one or the other?
- Can you tell me about any ideas you have about how the children you have worked with think and feel about taking medication?
- Does medication work? If so, what does it work on? If not, what are the reasons for continuing it?
- What do you think children think about having both treatments?
- What about families, and the wider network? What do they think about the child having both treatments?

- What about theory and/or research? Is there anything in particular you draw on in this sort of work?
- Have things changed, in terms if/how child psychotherapists are involved with children medicated for ADHD?

Appendix 6: Transcription conventions

S:	Precedes comments by Sarah, interviewer
(...)	Untimed pauses
[]	Explanatory material

Appendix 7: Development of researcher category 'Understanding of progress'

Text extract	Initial code	Researcher category
But even the school have noticed that she's kind of, you know, they've described how she's actually looked more, uh, they haven't said thoughtful but they've said you know, she, she's sometimes come back looking sad, which is not something that they often seen her be anything other than hyperactive.	Display of distress/ negative emotion as progress	Understanding of progress
she's been able to begin to show me some of her fieriness and her, her aggressive, aggressiveness with, um, and allowed me to comment, comment on her um, you know, sometimes her jealousies around the other children.		
And she's allowed me to sort of um, feel a You know I sort of have the the sense that she's possibly hearing me and absorbing and taking it in a little bit more more meaningfully	Capacity for tolerating therapist's reflections as progress	
she's tolerated my interventions more and more just sitting there with me, you know, and doing her activity, whereas before she would take flight I think.		
she's been able to begin to show me some of her fieriness and her, her aggressive, aggressiveness with, um, and allowed me to comment, comment on her um, you know, sometimes her jealousies around the other children.		
[School have] also commented that she's started talking about family members. And, and kind of just begun to differentiate between her foster carer and her mother	Changes in attitudes towards relationships as progress	

Appendix 8: Examples of memos

Memo 1: Psychotherapy and medication in competition

(Facilitated development of initial theme 'Competition')

When both psychotherapy and medication are used to treat a child, there is a sense that the two treatments can end up in competition with one another. Psychotherapy is portrayed as a limited, expensive resource, whereas drug treatment by a psychiatrist is more readily accessible. Competition is not inevitable, but is produced when both sides wish to take full ownership of the problem, rather than each attending to certain aspects. Psychotherapy is liable to end up on the losing side, due to the perceived speed and effectiveness of drug treatments, and marginalisation of psychoanalytic approaches. Participants are sympathetic with children's and parents' wish to choose the 'magic cure' of medication over the pain and commitment of the psychotherapeutic process. There is a sense that the very existence of a drug treatment places under threat families' capacity to choose and engage with psychotherapy, particularly for those families who are ambivalent about therapy. One treatment has to 'override' the other and they seem more likely to undermine than reinforce one another. For example one participant describes having 'informal Ritalin holidays,' once the psychotherapy was underway. Rather than being partners, the two treatments can become embroiled in a struggle to obtain the upper hand. Participants imply that medication's promise of a quick-fix is difficult to compete with – but also potentially illusory. Psychotherapy is then positioned as a more realistic 'fall-back' option, in the wake of the disappointing failure of medication. A sense of professional protectionism emerges. This may be exacerbated by political context – in particular in the NHS in which there is pressure to deliver short-term, cost-effective treatments and to have clear 'goals' in treatment, and also more broadly, also by Western reliance on and faith in quick-fix medical solutions.

Memo 2: Following rather than joining: integration is desirable but often not possible

(Facilitated development of initial themes 'Disempowerment' and 'Difficulties linking treatments')

Although there are one or two descriptions of good working relationships with psychiatrists, in which communication flows both ways, there is a sense of depending on the good will of the psychiatrist in determining whether there will be any capacity for thinking jointly. Child psychotherapists seem to position themselves as the followers rather than partners in decisions about treatment for ADHD. Whereas psychiatrists' orientation is identified as a key factor in deciding whether psychotherapeutic input is considered, child psychotherapists tend to stand back from inputting on decisions about medication, which seems to be felt to be outside the psychotherapist's remit. This may be partially determined by the psychoanalytic sensibility, which tends to prioritise thinking and understanding over acting. However there is also evidence that participants experience prescription for ADHD as an unpleasant fact that they (and children) have to accept and learn to work with. It is taken for granted that communication with the prescriber is important and desirable, but often this does not occur. The reasons for this are sometimes not clear to the participant.

**Child psychotherapy with children who are medicated for ADHD:
Discourse, power and interdisciplinary practice**

Appendix 9: Initial themes with clustered categories

Theory versus practice	Difficulties linking treatments	Approval of medication	Competition	Disempowerment	Compatibility
Co-operation is ideal not reality	No first-hand experience of medication effects	Expectations/prejudices challenged	Competition between psychotherapy and drug therapy	Medication decisions are not psychotherapist's business	Medication as extra support
Limited communication	Drug treatment does not affect clinical thinking	Benefits of medication reported indirectly	Psychotherapy as undervalued	Resignation	Medication facilitates therapy
Unfulfilled wish to engage	Interventions not treated as combined	Medication can improve compliance at school	Psychotherapy as disadvantaged	Limited involvement with treatment decisions	Links to neuroscience
Unfulfilled wish to integrate	Difficulty remaining with subject of psychotherapy and medication	Medication treats environment	Psychotherapy is not quick-fix	Dependence on psychiatric attitude	Same function/aim
Contrast between theoretical and clinical perspective	Uncertainty about medical side of treatment	Medication as solution to immediate difficulties	Medication chosen over psychotherapy	Disempowerment and frustration	
	Limited access to patient's experience of medication		Need for professional protectionism		
	Child's experience of medication not relevant/accessible				
	Child's play about medication not linked to drug treatment				

**Child psychotherapy with children who are medicated for ADHD:
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Appendix 9 contd.

Struggles with criticism	Disavowal of knowledge/expertise	ADHD as relational disorder	ADHD as defensive	ADHD as defensive (contd.)	Environmental complexity
Problematic critical discourses	Psychotherapists as new and/or inexperienced	ADHD as problem of self-regulation	ADHD as manic defence	Wish to understand not eradicate symptoms	ADHD child as overwhelming
Dangerous subject	Discomfort with language of the brain	Significance of early environmental trauma or deficit	ADHD as way of managing intolerable feelings	Alternative perspective on child	Reaction to crisis
Oscillation	Tentativeness and uncertainty	Psychotherapy aims to improve child's relational capacities	ADHD as defence against depression		Lack of thinking space
Ambivalence and confusion	Tentativeness about attributing cause and effect	Therapy addresses attachment issues	ADHD as relational and defensive in origin		Environmental complexity
		ADHD located in parents not child	ADHD as disturbance in thinking apparatus		Complexity and co-morbidity
		Relational model versus illness model	Psychotherapy aims to observe and integrate difficult feelings		Diagnosis fragments
			Therapy as painful/frightening		Psychotherapist's role in child's network
			Hyperactive symptoms as meaningful and hopeful		Therapeutic success against the odds
			Medication does not promote emotional development		Therapy as alternative to reactivity/collusion

**Child psychotherapy with children who are medicated for ADHD:
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Appendix 10: Central themes with sub-themes

Acceptance/approval	Ambivalence/uncertainty	Inequality
Compatibility	Struggles with voicing criticism	Competition
Theory versus practice	Disavowal of expertise	Disempowerment
	Difficulties linking treatments	
	Theory versus practice	

Meaningful communications	An alternative position	Communication breakdown
ADHD as defence	Environmental complexity	Difficulties linking treatments
ADHD as relational		Theory versus practice
		Process reflections